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ABSTRACT

The focus of this study was to review and analyze current programs, practices, and procedures of child mental health consultation in order to generate an in-depth, empirically derived, conceptual framework to assist in the development of new programs of training and research in consultation. The design of the study included the collection of data from ten sites within the United States having consultation to agencies serving children as part of their program. This volume contains a review of the literature on mental health consultation, a description of the procedures and the conceptual model used in this study, a summary of the results of ten site visits, and an evaluative analysis of the procedures and philosophy of mental health consultation as currently practiced. Data collection was accomplished by means of interviews utilizing semistructured and open-ended questionnaires investigating the procedures and theories of consultation described in the literature on mental health consultation. (Author)

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MENTAL HEALTH CONSULTATION TO PROGRAMS FOR CHILDREN

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NATIONAL INSTITUTE OF MENTAL HEALTH

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MENTAL HEALTH CONSULTATION TO PROGRAMS FOR CHILDREN

A Review of Data Collected from Selected U.S. Sites

A report prepared by

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Foreword to Second Printing

The necessity of a second substantial printing and updating of this publication indicates that it appears to fill an important need in planning and manning mental health consultation programs for children. Though not a manual on the "how" of consultation, the recommendations which are made concern themselves with specific ways the data from this study can be used in developing guidelines for systematic research on mental health consultation.

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Rockville, Md.
January 1972

Preface

This report is the result of a study conducted for the National Institute of Mental Health under contract number PH–43–68–618, covering the period from January 1968 through January 1969. Behavior Science Corporation (BSC) is pleased to have been selected as the research firm to conduct this study because of the importance of this area of investigation for the future of mental health programs in the United States. We wish to express our appreciation to some of the many persons who contributed to the project and without whose help it would have been impossible to complete a study of this size and complexity.

Dr. E. James Lieberman, former Chief, Center for Studies of Child and Family Mental Health of the National Institute of Mental Health, was the Institute's Project Officer for the preparation of this report. He originally saw the need for research into this critical area of mental health programs and developed the basic study design followed during the course of the research. Various staff members of the Institute gave assistance by participating in discussions about the project or by visiting sites as observers with the BSC staff. We wish to express our sincere appreciation to Dr. Allen Hodges, Dr. Marjorie J. Mack, Miss Nell McKeever, Dr. Gerald Sandson, Miss Pearl Shalit, Mr. Virgil Shoop, and Dr. Harvey Taschman.

Most important perhaps to the ultimate success of our efforts were the approximately 200 program directors, mental health consultants, administrative staff, and consultees at the sites visited by the BSC staff who were generous in giving of their time and who discussed openly the variety of their experiences in mental health consultation.

This, the final report, was prepared by Dr. Franklin B. McClung and Dr. Alastair A. Stunden, co-coordinators of the project for Behavior Science Corporation, who were also responsible for the development of the theoretical models and interpretation of the data contained in this report. Dr. Stanley C. Plog, President of Behavior Science Corporation, developed the original methods for collection of the data and served in the continuing role of Project Manager. Other members of the Behavior Science Corporation staff who participated in the conduct of the project include Dr. Steven Jacobs (responsible for the pilot phase of the study), Dr. George Davis, Dr. Louis Friedman, Dr. Glen Roberts, and Dr. Philip Smith, who functioned as members of the study teams during the site visits. Special thanks are gratefully extended to Mrs. Mildred Burkhalter for assistance in coordinating the many tasks necessary for the preparation of this manuscript.

BEHAVIOR SCIENCE CORPORATION

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Abstract

The focus of this study is to review and analyze current programs, practices, and procedures of child mental health consultation in order to generate an in-depth, empirically derived, conceptual framework which will assist in the development of new programs of training and research in consultation. The design of the study includes the collection of data from ten sites within the United States having consultation to agencies serving children as part of their program. Data collection was accomplished by means of interviews utilizing semistructured and open-ended questionnaires investigating the procedures and theories of consultation described in the literature on mental health consultation.

Mental health consultants having a variety of professional responsibilities and backgrounds were interviewed as well as an equally broad range of persons receiving consultation. Interviews, which incorporated the questionnaires, were conducted by professional staff members of Behavior Science Corporation. The data from the interviews at each site were coded and analyzed, and summary reports reflecting the findings were prepared. These empirical data were subsequently reduced and collated and models representative of different types of consultation, as defined by the observed data, were abstracted.

This volume contains a review of the literature on mental health consultation, a description of the procedures and the conceptual model used in this study, a summary of the results of the ten site visits, and an evaluative analysis of the procedures and philosophy of mental health consultation as currently practiced. Detailed descriptions and analyses of consultation practices and goals at each of the ten sites visited are available on special request from the Center for Studies of Child and Family Mental Health, National Institute of Mental Health.

Chapter 1

Introduction

The study described in this report has been an arduous but exciting undertaking. It is not a simple procedure to attempt to describe, let alone conceptualize, the current directions of child mental health consultation in the United States. And yet to ". . . summarize the range of current practices and procedures related to child mental health consultation services" was the task requested by the National Institute of Mental Health.

This task has been particularly stimulating because of the innovative developments that are rapidly taking place in professional areas specifically related to mental health consultation. For example, with the rapid development of community mental health centers made possible by the Community Mental Health Centers Act of 1963, the thrust of mental health efforts has turned away from hospitalization and intensive treatment toward programs which are aimed at the prevention of emotional illness. Chief among these programs of prevention is mental health consultation. For many agencies these consultation efforts have a primary focus on children, for mental health experts agree that the most effective time for prevention of emotional disorders is during the childhood years. Motivated by this specific area of need, various theoreticians and pragmatic planners throughout the nation have been developing new ways for offering a broad range of consulting services that will have maximum impact on the total community.

To provide order, it was imperative to develop a conceptual model which encompassed the necessarily diverse range of current practices in child mental health consultation. This conceptual model is described here together with a review of the consultation literature, a description of the procedures and methods of the study, the basic findings, a discussion and analysis of their implications for current and future practices in mental health consultation, and suggestions of areas in which research is critically needed.

Detailed descriptions of each of the programs at the specific sites visited provide the raw data from which the interpretive analysis and conclusions were derived. These site descriptions are available on special request from the Center for Studies of Child and Family Mental Health, National Institute of Mental Health.

Each site report consists of the following sections:

- *Description*

  This section is an overview of the geo-political locale of the site, as well as a description of the type of mental health facility, its staff, and a discussion of the relationship of the facility to the surrounding community.
- *Establishing the Consulting Relationship*

  This section contains a description of the procedures for initiating consulting contracts and the factors influencing those contracts which are characteristic of the particular site.
- *Procedures of Consultation*

  This section is devoted to a description of the various consultation programs in existence at each site and a detailed analysis of that type of consultation given major emphasis by the consultant agency.
- *Attitudes, Philosophy, and Goals of Consultation*

  This section is a discussion of the purposes and philosophy of consultation prevailing at each site.

In this study there have been conceptualized six different types of mental health consultation descriptive of a range of current programs in the United States. The conceptual model presented is based on empirical evidence, even though the study was not an experimental one. The information developed by this study will supplement standard reference works on community mental health; it will also be useful as a guide for persons interested in conducting mental health consultation and in the training of mental health consultants.

Chapter II

Review of the Literature

A CULTURAL PERSPECTIVE FOR MENTAL HEALTH CONSULTATION

A discussion of the literature and current status of mental health consultation would be sterile without a description of some of the forces operating in the broad area of mental health. Insofar as the theory, practice, and goals of mental health consultation are derived from the practice of psychotherapy, the revolution in therapy that has been occurring over the past 15 years has been central to the evolution of community mental health practices.

Prior to 15 years ago, psychotherapy operated within a comfortable orthodoxy. Deviations were viewed tolerantly as additions or modifications to the well-established guidelines which let every therapist know who he was and what he should or should not do.

Beginning in the early 50's and accelerating during the past decade, the traditional orthodoxy of Freudian theory, which for so long provided guidelines for the professional therapist, has been questioned and found wanting for the solutions to problems of community-wide scope. The vacuum left behind has yet to be filled. If anything can be viewed as characteristic of the mental health field during the past 15 years it is diversity and controversy. In current slang, everyone is doing "his own thing," and for every practice or theory there is an equally vocal opposite. There is Now therapy, Reality therapy, Leaderless group therapy, Marathon therapy, Sensitivity training, "consciousness expansion" (with and without drugs), and even explorations into nude therapy. Each of these innovations has attracted dedicated followers and equally dedicated critics.

Among those authorities who advocate complete overhaul of the mental health field are strong proponents of the position that a well-trained psychotherapist should never spend his valuable time seeing a patient directly. He should instead disseminate his expertise through hundreds of less-trained personnel, who are, in turn, working directly with people, thereby effecting a broader base of social ills. Nevertheless, at the opposite pole are those authorities who claim that professionals trained primarily in psychotherapy have no business doing anything other than psychotherapy. Both positions have some rational basis but generate emotional reactions far beyond the logic involved.

Emotional advocacy of a position does not contribute to solutions. What is desperately needed in the mental health field now are models which will help suggest answers to questions such as:

- Who should be the patient?
- Who should treat the patient?
- How should he be treated?
- Why should he be treated (goals of treatment)?
- What is the theory supporting this treatment?
- What relationship should the mental health professional have to the patient (client), community, nation, and world?
- Should he even be called the patient? Are terms such as illness, treatment, therapy, and patient really relevant to community social problems?

It is astounding that such crucial questions have no accepted answers when one realizes that only 15 years ago there was not only general agreement but accepted answers that were viewed as self-evident truths. Revolutions do not just happen; they emerge from a confluence of forces that make revolution inevitable. A look at these forces should be helpful in providing a context for the description of mental health consultation that follows in this report.

End of an Era

The traditional practice of intensive long-term psychotherapy has often been challenged to provide evidence that it worked. Hebb (1948) presented the thesis that there was no hard evidence to demonstrate that psychotherapy was better than no treatment at all. Eysenck (1952) went so far as to make the claim that there may be an inverse relationship between the amount of treatment and the rate of recovery. The bases Eysenck used for his conclusions have not gone unchallenged, but no research has appeared to refute his opinions. Instead it has become apparent to critics of traditional therapy that practitioners were continuing to use these techniques in the absence of scientifically acceptable validity. The foundation was thus prepared for therapy innovators to appear not as rebels but as rescuers.

Doctor-Shortage Crisis

The second element which had been present for many years, but which was not considered to be a crucial social problem until recently, was the critical shortage of trained personnel to carry on mental health treatment (Hollingshead & Redlich, 1958). The familiarly accepted one-to-one technique of therapy began to be viewed as terribly wasteful of the therapist time available. Furthermore, in the sixties, concrete statements about the enormous numbers of people with emotional problems who were untreated began to be made public. For example, the American Psychiatric Association (1964) estimated that as many as 4.5 million children in the country were badly in need of treatment. Obviously it would not help the immediate personnel crisis of it were necessary to wait 10 or more years before new mental health recruits had completed their academic training and became available. Either new techniques had to be devised to use more efficiently the trained professional, e.g. mental health consultation, or people without professional mental health training had to be recruited and put to work. As is well known, both of these steps have been recently taken, and both movements arouse controversy.

Patient-Population Explosion

A third factor, which has served to magnify the manpower shortage greatly, has been the socio-cultural pressure to extend mental health services to large populations which heretofore had not benefited from the main stream of treatment. For example, millions of mentally retarded children and adults up to now had been largely ignored, partly because of society's guilt, and partly because of the general reluctance of mental health professionals to work with this population. As a result, the two to four million mentally retarded had been relegated to a therapeutic limbo. Recently, with advances in pharmaceutical and educational techniques, there has emerged an increasing demand for treatment to replace custodial care.

A second example of the socio-cultural pressure for mental health services is the explosion in the numbers of socially maladjusted teenage children, essentially a phenomenon of the 60's. Many statements have appeared in popular media claiming that as many as half the enrollment of junior high school and senior high school students have participated in either drug use, pre-marital sex, or both. An alarmed coalition of educational authorities and parents has commanded the mental health professions to give a high priority to the treatment of these social problems.

The numbers within the two categories above, although in millions, are dwarfed by the tens of millions of economically deprived people who are now looking to the mental health professional for assistance. Poverty is no longer understood to be a simple problem of lack of money or employment. Insights into the motivation, attitudes, goals, and behavior of the chronically poor are now considered central to any solution, and the mental health professional is the man on the spot to produce these insights.

Some authorities contend that the mental health professional has contributed to the severe shortage of trained personnel by identifying problems, formerly considered only political or economic, as a legitimate area of responsibility for the professional trained in the treatment of mental illness. Irrespective of the way in which these cultural and economic problems have been included in the domain of the mental health professional, the present reality is that they are included. In the face of these demands for an overwhelming amount of urgently needed services, the need for radical surgery on all preconceived ideas about the mental health field is both mandatory and immediate.

The Necessary Catalyst

Into this field of interacting forces, the intervention of city, State, and Federal Government agencies, with their large funding programs, provided the means for the mental health field to put into operation many different attempts to meet this crisis in treatment. Although several Federal agencies have provided funds in their specific areas, e.g., education, welfare, housing, and urban development, the National Institute of Mental Health through the Community Comprehensive Mental Health Centers Act of 1963 has been the main stimulus motivating professionals to attack the tremendous job of facing up to the social crises and trying to do something about them.

The need for conceptual models, soundly based on research findings, is never so great as when a broad area of man's endeavors, either cultural or scientific, is undergoing a dramatic upheaval. Understandably, that is the very time during which such badly needed guidelines are missing. The old traditional ways have been called into question and found wanting. The replacements, revolutionary one day, orthodox the next, are not yet available. During this transition state, the mental health field must of necessity react to each crisis in the most expedient way available. Until models can be evolved, tested, and given goal-direction relevant to society as a whole, the ad hoc reactive pattern will prevail. Evaluation and conceptualization permitting the development of models are more immediately needed now than are more trained people or more facilities.

Role of Consultation

Consultation in the current mental health effort has emerged not so much as a tool but as a whole new direction for the field. It is understandable that a great deal of controversy surrounds the subject. The position that a professional takes concerning the question of whether the mental health field should or should not go in this direction implies a position on some very touchy issues. Should mental health workers operate within a medical model, i.e., treat only those patients who come to him for help, or should he operate within a public health model and go out into the community and intervene in those situations which threaten the community well-being?

Those workers who choose to follow the prevention path are faced with questions of values which did not exist in the area of the prevention of physical disease. One such value question is: Should a mental health worker go to people who have not asked for help and attempt to change their life style and living environment? When this question is faced and is answered in the affirmative he is confronted by a further value question: To what degree should a mental health worker be involved in political and social action? This value question applies only to his involvement as a human behavior expert, not to his rights as a responsible citizen.

The crucial issue remains: What are the goals of the mental health profession? Are they to include changes in society aimed at facilitating mental health? Some have defined the goals as increased adaptability and ability to cope with social demands (Rae Grant, Gladwin & Bower, 1966). Others have challenged this position on the grounds that efforts should concentrate on modifying the entire social structure in a "healthy" direction. In turn this "social engineering" position is challenged, e.g. ". . . when positive mental health is set as the target for therapy . . . a rationale is subtly but nonetheless surely laid for the treatment of the relatively healthy patient" (Lapouse, 1965, p. 143).

In summary, there is presently no more consensus in regard to consultation than there is in the field of psychotherapy. An increasing number of workers in the mental health field recognize that consultation is expanding and can only continue to do so in a positively accelerated manner. There is no controversy in regard to the need for the definition of goals, only as to what those goals should be. There also is unanimous agreement on the need for evaluation programs, but disagreement on how these programs should be conducted. A look at child mental health consultation, both historically and as now practiced throughout the country, can tell us where it has been and where it is now. Such a look may also suggest where it should go in the future.

REVIEW OF THE LITERATURE ON CHILD MENTAL HEALTH CONSULTATION

Within the field of mental health consultation, there is no distinction in theory or practice between consultation to adult-care agencies and

consultation directed solely toward child-caring agencies. Administratively, consultation is not separated on an adult-child dimension. For most mental health agencies, time devoted to consultation is spent primarily in working with child care-giving agencies, such as schools, probation departments, public health agencies, etc. For these reasons, literature references on all types of consultation are assumed to apply equally to child and adult consultation problems.

EARLY EFFORTS IN MENTAL HEALTH CONSULTATION

Most consultation prior to the mid-1950's either was didactic education or it followed the medical model of a consultant, usually senior, discussing a specific case with a junior. The distinction between education-consultation and supervision-consultation was not clearly established. The typical situation would include a psychiatrist, in most cases psychoanalytically trained, overseeing social workers who were working with simpler or less severe problems. Sloan (1936) described this practice and saw it as a means of extending the psychiatrist's role. He also stated that the worker made interpretations to the patient only after "consultation" with the psychiatrist. This form of consultation is still prevalent in many mental health agencies, particularly where the agency director, usually a psychiatrist, has had training for traditional private practice only.

Goldman (1940) described the main functions of a consultant as (1) diagnosis and prognosis, and (2) education of staff within the mental health facility. Other authors (Coleman, 1947; Maddux, 1950) mention the usefulness of consultation in providing reassurance for the social worker, helping to anticipate problems in treatment, and particularly in exploring the patient's feelings toward the psychiatric social worker.

Many writers in the late 1950's and early 60's (Berlin, 1960; Bindman, 1959; and Caplan, 1961) placed considerable emphasis on the need for mutual respect and acceptance by the consultee's expertise in his own field. Prior to the end of World War II, however, there was no mention of this in the literature. The total absence of consideration of the status relationship leads one to believe there was complete acceptance of the superior-subordinate nature of consultation within the medical model. As consultation evolved toward the public health model, the status relationship changed toward that of equal colleagues from different fields resolving a problem of mutual interest.

In the late 1940's there was a significant shift from the emphasis on working directly with the client toward focusing attention on the consultee. This trend did not develop rapidly until the late 1950's and is still increasing. Coleman (1947) was the first writer to describe consultee-oriented consultation. He emphasized that the consultant should always obtain administrative permission for his activities and that consultation should be done only with mutual agreement between consultant and consultee. In addition to the education-vs.-consultation and supervision-vs.-consultation confusions, a more recent development has led to the therapy-vs.-consultation conflict and confusion. Obviously it would require great skill for the consultant to discuss the "caretaker's" difficulties in handling specific children without crossing the borderline and making unsolicited comments on his personal problems. In some situations consultation was deliberately structured as quasi-therapeutic. Kaufman (1953) and Aldrich (1953) discuss the integration of psychiatry with medical practice in a general hospital setting, the aim being to help the physicians become more aware of the patient as a complete person and of their own emotional reactions to that patient. In this same setting, medical students in training also were encouraged to use consultation sessions to discuss their fears and feelings of personal and professional inadequacy. Bibring (1956) used group therapy sessions with medical students as a consultation medium. Berman (1954) moved out of the medical setting and conducted group sessions with 10 to 15 educators exploring their emotional reactions to their daily work. The current, highly sophisticated programs of Scheidlinger (1968) at Lincoln Hospital, Bronx, N. Y., with the Department of Pediatrics, and Minuchin (1968) with the hospital staff at Philadelphia Children's Hospital are modern extensions of these early efforts.

The subservient position of the medical student to the medical school staff and the traditional position of the social worker therapist as ancillary to the psychiatrist fostered the superior-subordinate status in consultation, as well as

permitting the consultee's personal problems to become an acceptable subject for consultant attention. As the range of consultation efforts spread beyond the medical setting, these conditions no longer were present. In the non-medical setting, considerable resistance, implied or overtly defined, to subordinate status was encountered, and a genuine defensiveness on the consultee's part arose against being "psychoanalyzed" at a time when the consultee wanted help with an immediate client problem. Consequently, there was a rapid shift in the late 1950's and early 1960's back toward an emphasis on child-client problems. Accompanying this shift in emphasis was the emergence of the "colleague" relationship between the consultant and consultee (teacher or other professional). Similarly, there was also a perceptible shift away from advising or giving direct problem-solving suggestions toward the goal of developing in the consultee the skills to resolve problems by himself. This, in general, is the basic philosophy most prevalent today. However, there is a lack of agreement on methods or means to achieve these goals.

The current philosophy of skill development in the consultee, while avoiding the practices of therapy or "instant problem-solving," did not originate with Caplan, but he was the first to offer a formal definition of the philosophy as a systematic process (1961, 1963).

One of the important contributions by Caplan is his defense of consultation as a legitimate discipline for the mental health professional. All theoreticians may not agree with him, but to Caplan it is a way in which the professional can reach out to a larger population than he could see on a one-to-one basis. The professional does this by helping "caretakers," who are not mental health specialists, understand the mental health aspects of their jobs, and, therefore, deal more effectively with their clients.

The relationship of the consultant to the consultee as a collaborator necessitates acceptance of status equality by both parties. Responsibility for the client remains with the consultee, and he is free to accept or reject suggestions made by the consultant. Caplan (1964) stresses the need for the consultant to avoid being an educator, a supervisor, or a therapist, and to remain a catalyst who facilitates the helping relationship between consultee and client. One of the major difficulties in Caplan's model is his emphasis on dealing directly with the consultee's unconscious processes (theme interference) while avoiding the therapist-patient role (1963). In practice this has been a very difficult task for most consultants who subscribe to his theoretical system.

Specifically, Caplan (1963) delineates four types of consultation:

1. Client-centered case consultation
2. Consultee-centered case consultation
3. Consultee-centered administrative consultation
4. Program-centered administrative consultation

According to Caplan the four types of consultation are distinguished as follows:

- Client-centered case consultation is focused on helping the consultee find the most effective treatment for his client.
- Consultee-centered case consultation has as its goal helping the consultee locate his work difficulties and helping him work through these difficulties.
- Consultee-centered administrative consultation focuses on the consultee's relationship with the people and programs within the agency and will usually include discussion of the consultee's role in relating to superiors and subordinates.
- Program-centered administrative consultation has, as the subject of discussion, a program or programs of concern to the agency. The agency administrator is usually the conconsultee and the consultant is expected to contribute in a variety of ways to development of a viable program.

In his various writings, Caplan (1956, 1961, 1963, and 1964a) spells out many specific difficulties and the techniques for handling them in each of his four categories of consultation.

CURRENT PHILOSOPHY AND PRACTICES IN MENTAL HEALTH CONSULTATION

Status Relationships

Berlin (1960, 1964a) stresses the distinction between consultation and psychotherapy by making the co-equal status between consultant and consultee central to the relationship. He emphasizes that this relationship requires great skill and considerable time to develop. To Berlin, it is essential that the consultant have this distinction clearly in mind when he attempts consultation so as not to fall back on the therapist role when he encounters difficulty.

Bindman (1959) describes this distinction of role as "authority of ideas" as opposed to administrative authority or the authority implicit in the therapist-patient or the teacher-student relationship. Gaupp (1966) writes that a primary aim of consultation is to promote the greatest amount of independence and judgment on the part of the consultee. He distinguishes between authority based upon enforcement and authority based upon knowledge. Gaupp continues that administrative pressure is a disturbing factor in consultation. Administrators with their concern with power, status, and leadership are often reluctant to seek consultative help for themselves because they feel that asking for help is an admission of their own lack of capability. Berlin (1964), Bindman (1959), Caplan (1964a), and others stress that the consultant should not make decisions or assume responsibility. Also, the consultee must be free to accept or reject any suggestions.

Implicit in many writings of the current era is an additional subtle distinction. In therapy, a frequent goal is the weakening or changing of the patient's defenses. In consultation this seldom would be the goal; rather, the bolstering and strengthening of the defenses of the consultee would be typical.

Another role problem the consultant faces is the frequent expectation, by the consultee, of instant magical solutions. This problem is sometimes compounded by the consultant's own anxiety and need for success. Berlin (1964a) warns against this trap and stresses that adequate training and supervision is the best preventative.

Focus of Consultation

Currently, most consultants feel that consultation should occur on the premises of the consultee. The hope is that the consultant will be identified with the agency, in which case, consultation becomes an integral part of their work rather than isolated from it. Green (1955) states that this requires an unusually secure consultant who will be comfortable working in a wide range of unfamiliar situations. Hollister (1965) recognizes the potential difficulties inherent in a consultant who has a need to prove himself and who may express this need through his attitude of "rescuing" an agency from itself. This attitude would obviate the mutual respect necessary as a foundation for a sound consultation relationship.

Therapy Versus Consultation

Current practices of consultation are perhaps best described by the manner with which the therapy versus consultation distinction is handled. Two of the most prolific writers in the field of mental health consultation, Caplan (1963) and Berlin (1960), devote a major portion of their descriptions to the parameters and difficulties inherent in the way the consultant deals with the personal problems of the consultee. Caplan, through his concept of "theme interference," bases his consultation procedures on the consultant being sensitive to the unconscious processes of the consultee (themes) which are causing difficulty in the client relationship. These unconscious processes are not dealt with directly as intra-personal problems but indirectly through a discussion of the *client's* problems. Thus, Caplan measures the effectiveness of consultation by observing changes in the types of client problems brought to the consultant and the increasing ability of the consultee to see and handle those client problems which were the subject of his "theme interferences."

Berlin (1956, 1960, 1965) also stresses the part played by the consultee's internalized conflicts in his work with clients. In this mode, any reference to the consultee's private life is also strictly avoided. Berlin emphasizes the value of permitting free expression, in group settings, of consultee's feelings of frustration, guilt, and hostility toward his clients. The recognition, by the consultee, of the commonality of these attitudes in other workers permits him to see the situation in a problem-solving rather than a defensive way.

Other writers also stress the central nature of the intra-personal problems of the consultee. Bindman (1964) states that the client may serve as the object of displacement for the consultee's own problems, thus preventing the consultee from functioning objectively in his relationship with the client. Bindman goes on to say that the consultant must provide a supporting "accessory ego" for the consultee rather than attacking the displacement phenomenon. Newman (1964) disagrees with Caplan, Berlin, and Bindman by dealing directly with the feel-

ings and theme interference of the consultees; however, she emphasizes the need to make interpretations at the immediate behavior level rather than in etiological, historical terms.

Altrocchi, Spielberger, and Eisdorfer (1965) have found that, when consultees are allowed to present their own feelings and problems openly, the other group members are able to handle these with both sensitivity and appropriateness. These authors go on to emphasize the importance in consultation of reducing the consultee's anxiety and/or guilt. This may be done by the consultant having a realistic view of his own limitations and freely expressing them in consultation sessions. Berkovitz (1968) also makes the point that consultation is not the panacea for all problems. Berlin (1962) cautions against the consultant playing the role of expert in all fields and thereby encouraging the dependency of the consultee and reinforcing his feelings of inadequacy.

Consultant Contact With Children

The question of the amount of contact the consultant should have with the consultee's client has been examined extensively. Berkovitz (1967) recognizes the danger, in the school setting, of the consultant circumventing the school psychologist by directly seeing children. However, he indicates that observation of the child in the classroom sometimes is helpful to the consultant. Newman (1964) makes classroom observation an important step in school consulting. Caplan (1963) goes beyond the observation level and states that in case-conference consultation, where the immediate goal is to help the consultee find the most effective treatment for the client, the consultant may frequently examine a client for diagnostic purposes.

The difficulty in establishing clear ground rules for the extent and intent of client contact with consultee's clients stems from the common situation where direct client service and consultation are intermingled. A typical example of this problem is cited by Schwartz and Deran (1967) who describe an agency service center providing both direct services and consultation to non-mental health agencies. In this description, services and consultation often were indistinguishable, including advice given by telephone, direct service in the client's home or consultee office, and emergency on-call availability. The experiences in this one agency are illustrative of the current situation in which individual mental health professionals, representing a community mental health facility, will usually relate in many different ways to the personnel of a consultee agency. The confusion of roles is understandable; it reflects both the lack of consistent models of consultation practice in a rapidly changing world and the desperate pressure from non-mental health agencies for more services than can possibly be provided by present facilities.

Initiating Consultation

The contractual commitment between the consultant and the consultee agency is the essential element in the preparation for the initial stages of consultation. This implied or contractual commitment in the consulting relationship is not a one-way agreement. Caplan (1963) and Adams (1966) write about the need for sanction from all levels of administrative authority, particularly the top. Berkovitz (1967) adds that the sanction from administration may be only tacit and that much covert resistance to the "intrusion" of the consultant may be present, thus interfering with consultation practices. Thus the needs and obligations of both agencies must be explicit, and the contractual agreement must recognize these if there is to be a successful collaborative effort. Of particular importance in this phase is who does the seeking. Where the consultee agency comes to the consultant and asks for his services, the consultant is in a much better position to establish conditions he considers appropriate for effective consultation. The needs of the consultee agency are known and accepted; however, the needs, requirements, and satisfactions desirable from the consultant's side of the contract do not always receive such universal recognition.

Haylett and Rapaport (1964) discuss the initial phase of consultation as being confined to the consultant and the top agency administrator. The purpose of this phase is to obtain sanction from the administration to operate within the agency. They also comment that the contract should be renegotiated annually and should include evaluation of the past program and a discussion of any changes contemplated. Berlin (1956, 1964a) points out that services must begin at the level at which they will be

accepted. He discusses an example where, owing to the anxiety of the school principal, consultation had to be withdrawn until it could be more gradually introduced.

The most elaborate discussion of the process of introducing consultation is to be found in Brown (1967). These steps, as he describes them, are:

- Identification of the consultee groups. Emphasis is on the use of mutually comprehensible language.
- Mutual agreement of goals and time commitment in terms of consultees' needs.
- Examination of the relevance of consultees' needs to the professional skills of the consultant. Evaluation of unconscious needs as well as those stated overtly are included in the review.
- Clarification of misperceptions by consultee regarding limits of consultants and the correction of "magical solution" fantasy.
- Development of awareness by the consultant of the ways his relationship with consultee group will effect their relationship with other groups.
- Development of awareness by the consultant of the power and authority relationships within the agency and between the agency and the community.
- Exploration of consultee's previous experience with mental health personnel as well as alternatives to consultation.
- Establishment of the means for evaluating the effectiveness of consultation in terms which are meaningful to consultee.

The initiation of consultation, as discussed by Brown, has been summarized because it is a concise description of the conditions for establishing the consultation contract which permit a mutually satisfactory relationship to evolve. It should be noted that Brown emphasizes the needs of the consultee agency to the exclusion of the needs of the consultant or his agency, such as professional training, job expectations of the consultant, etc.

Other pathways to the establishment of consultation have been followed. Schwartz, Paul, and Schuntermann (1967) describe meetings with a teacher group, a child group, and a parent group for a period of six weeks prior to establishing a formal consultation relationship. They believe this technique facilitated a collaborative relationship with the school and prevented unrealistic expectations from consultation.

Schiff and Kellam (1967) at Woodlawn developed over a 1-year period a program which included meeting with school personnel, parents, and local community leaders. This program permitted them to operate effectively within a setting originally hostile to their presence.

The idiosyncratic nature of each community and the heterogeneity of agency personnel suggest that, in the crucial phases of negotiating the consultation contract and establishing the consultant-consultee relationship, modifications will need to be made in any general formula which may be evolved.

Consultation to Groups Versus Consultation to Individuals

Green (1956) values group consultation for the variety of personalities involved, which provides opportunities for awareness of a wider range of reactions to a specific case. Altrocchi, Spielberger, and Eisdorfer (1965), Newman (1967), and Rowitch (1966) emphasis the value of group meetings for improving communication with an agency. Berlin (1964a), Bernard (1955), and Green (1956) feel it is highly desirable to have supervisors and subordinates in the same consultation meeting. They state that the presence of the supervisor precludes the possibility of the consultant usurping his position. Also, the sanction of the administration for particular suggestions is immediately available. These authors caution against the possibility that free discussion may be inhibited in a mixed level group, depending on the personality of the supervisor.

Rowitch (1966) makes the point that meeting in groups will tend to minimize the danger of consultation becoming psychotherapy. He states further that groups will tend to stick to reality issues and remain more task-oriented. Berkovitz (1967) adds his opinion to those writers who encourage mixing all levels of staff in the same group.

Consultation to Schools

Public schools are the recipients of the major portion of mental health consultation to children. As such, the area of school consultation deserves the special attention it has received in the literature.

Berkovitz (1968) discusses the consultation provided by the Los Angeles County Mental Health Department to large and small school districts in the greater Los Angeles area. He identifies three categories of personnel receiving consultation. These are, in the order of priority he assigns to them: administrative, specialized remedial, and teaching. He states that, within a school district, consultation time should be divided equally among these three groups. Berkovitz further describes efforts to evaluate the effectiveness of various group mixes of these three groups with no conclusions as to which combination is best.

Rowitch (1966) feels that totally integrated groups, including principal, specialized personnel, and teachers, are optimal. He cautions, however, that such a grouping requires a non-authoritarian principal who can support the program without dominating it.

Berlin (1954, 1965) has a fundamental concern with secondary prevention. This involves both the early identification of emotional disturbance and the early intervention of the educator through the consultation process. The consultant also serves as a counterbalance to the administrative and community demands on the teacher by developing expectations for the teacher which are realistic.

The special problems created for the consultant in the schools by the fearfulness of many teachers and the guardedness of many administrators is mentioned throughout the literature. Berlin (1965) stresses the need for the consultant to be aware of these factors and to proceed carefully, letting the needs of the consultees develop gradually in as non-threatening a way as possible.

Training in Mental Health Consultation

There are only a limited number of programs for the formal training of mental health professionals in the techniques and theories of consultation, considering the overwhelming need for such trained people. Examples of training centers with a national impact are the Division of Child Psychiatry, University of Washington, Seattle, Washington; The Laboratory for Community Psychiatry, Harvard University, Cambridge, Massachusetts; the Philadelphia Child Guidance Clinic, Philadelphia, Pennsylvania; and the Division of School Mental Health, The Menninger School of Psychiatry, Topeka, Kansas.

The specific content that training programs should have varies considerably among authorities. Bindman (1964) stresses five areas of knowledge which he considers necessary. These are:

- A thorough knowledge and experience in individual and group psychotherapy.
- Sufficient supervision so that the consultant understands himself and his relationship with others.
- Thorough knowledge of diagnosis by means of behavioral and secondary cues.
- Training and experience in educational methods.
- Some knowledge of social psychology, institutional structures, and community organization.

Parker (1961) states that the usual psychiatric training may be a detriment for mental health consultation. She lists four areas of potential difficulty:

- Lack of experience in group techniques.
- Lack of knowledge about attitudes and job problems of other professional groups.
- Biases from previous methods of psychotherapy.
- Anxieties which arise from having to deviate from the medical model.

Both Bindman and Parker, although differing in their views on the requirements for consultation training, agree emphatically on the value of supervised experience as a training mode.

Non-Professionals as Mental Health Workers

There is general disagreement on the value of using persons other than professionally accredited mental health personnel to perform mental health work.

Stickney (1968) recommends the training of teachers as therapeutic aides within schools. Wallace (1967) and others stress the need for using local residents as mental health aides to programs in socially and economically deprived communities. Hallowitz (1967) describes the program in the Bronx and Harlem, New York, which consists of Walk-In Neighborhood Service Centers staffed almost entirely with indigenous non-professionals.

On the other hand, Whittington (1966a) feels that consultation should be given only by persons having some basic professional training

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and identification. He is concerned that failure to make this limitation may encourage untrained persons to present themselves as professional practitioners.

Evaluation

The need for systematic evaluation of every phase of mental health consultation is mentioned in almost every paper written in the field. Without exception, these authorities place this need at the top of a list of priorities, before the need for more personnel or more facilities and even ahead of more training. In spite of this, a search of the relevant literature reveals no research of sufficient scientific exactitude to permit replication. There can be no doubt that filling this void is the first step in providing order and structure to the controversy and confusion about consultation.

Chapter III

Procedure and Methods

INTRODUCTION

This study focuses on child mental health consultation as currently practiced in a number of reputable programs across the United States. The purpose is to derive empirically a conceptual framework for use in future program development, training, and research. The design included collection of data from ten sites where mental health consultation was provided to community agencies serving children (most commonly, schools). Data were collected in interviews using questionnaires. Delimited and open-ended questions were designed to explore the procedures and theories of consultation found in the literature. Interviews were conducted with both consultants and consultees by members of the staff of Behavior Science Corporation. Data from each site were coded, analyzed, and summarized.

SITES

Ten sites within the United States which offered mental health consultation services for children were selected. Before the final decision was made as to the ten sites to be visited, a large number of sites which met the approval of the National Institute of Mental Health were considered. Programs were sampled that would be representative of a variety of geo-political areas as well as a broad range of catchment areas. An attempt was also made to sample programs that were receiving support from the National Institute of Mental Health through the Comprehensive Community Mental Health Centers Act of 1963. Factors influencing the final selection included: special program emphases, the presence of a professional training program in consultation, on-going research on consultation, and relevant contributions to the literature. In the last analysis, only those programs having a reputation for excellence within the professional community were chosen.

The ten sites selected for the study are listed below by location, administrative head, official title of the agency, and those agency functions which are relevant for this report.

Site 1

SEATTLE, WASHINGTON
Irving N. Berlin, M.D.
Professor of Psychiatry and Pediatrics
Head, Division of Child Psychiatry
School of Medicine, University of Washington

- Mental health consultation for children
- Professional training in mental health consultation
- Contributions to the mental health consultation literature

Site 2

TOPEKA, KANSAS
Marvin Ack, Ph.D.
Director, Division of School Mental Health
The Menninger Foundation

- Mental health consultation for children
- Professional training in mental health consultation

Site 3

PHILADELPHIA, PENNSYLVANIA
Salvador Minuchin, M.D.
Director, The Philadelphia Child Guidance Clinic

- Mental health consultation for children
- Professional training in mental health consultation
- Contributions to the mental health consultation literature

Site 4

NEWTON, KANSAS
Elmer Ediger
Administrator, Prairie View Comprehensive Community Mental Health Center

- Mental health consultation for children

Site 5

CHICAGO, ILLINOIS
Mrs. Jeannette D. Branch, M.A.
Director, Woodlawn Mental Health Center

- Mental health consultation for children
- Experimental research on consultation

Site 6

The State of Colorado

ENGLEWOOD, COLORADO
Thomas D. Nelson, Ph.D.
Director, Arapahoe County Comprehensive Community Mental Health Center

- Mental health consultation for children

ADAMS CITY, COLORADO
Henry Frey, M.D.
Medical Director, Adams County Comprehensive Community Mental Health Center

- Mental health consultation for children

GREELEY, COLORADO
Donald Jenson, M.D.
Director, Weld County Comprehensive Community Mental Health Center

- Mental health consultation for children

PUEBLO, COLORADO
Charles E. Meredith, M.D.
Superintendent, Colorado State Hospital

- Mental health consultation for children

GRAND JUNCTION, COLORADO
James R. Wilson, M.D.
Director, Mesa County Health Department

- Mental health consultation for children

Site 7

GRAND RAPIDS, MICHIGAN
Gerald VanderTuig, M.S.W.
Director, Grand Rapids Child Guidance Clinic

- Mental health consultation for children

Site 8

SAN MATEO, CALIFORNIA
Howard Gurevitz, M.D.
Program Chief, Mental Health Services Division
San Mateo County Department of Public Health and Welfare

- Mental health consultation for children

Site 9

The City of New York

BRONX, NEW YORK
Gabriel Koz, M.D.
Director, Lincoln Hospital Mental Health Services
Albert Einstein College of Medicine—Yeshiva University

- Mental health consultation for children

MANHATTAN, NEW YORK
Virginia N. Wilking, M.D.
Chief, Division of Child Psychiatry
Harlem Hospital Center

- Mental health consultation for children

MANHATTAN, NEW YORK
Alan Levy, M.D.
Chief of Liaison, Psychiatric Unit
Beth Israel Medical Center

- Mental health consultation for children

MANHATTAN, NEW YORK
Archibold Foley, M.D.
Director, Division of Community and Social Psychiatry
The Faculty of Medicine, Columbia University

- Professional training in mental health consultation

MANHATTAN, NEW YORK
Gerald Emmet, M.D.
Chairman, Committee on Mental Health Consultation to Schools
New York Council of Child Psychiatry

- Mental health consultation for children

Site 10

LOS ANGELES, CALIFORNIA
Harry R. Brickman, M.D.
Director, Central Preventive Services Division
Los Angeles County Mental Health Department

- Mental health consultation for children

The Laboratory of Community Psychiatry under the direction of Dr. Gerald Caplan, Clinical Professor of Psychiatry, Department of Psychiatry, Harvard Medical School, was one of the ten sites originally selected for a site visit. At his request, due to circumstances concerning the consultation program, it was not included in the study. Dr. Caplan's writings were, of course, included in the literature survey.

QUESTIONNAIRE

Two questionnaires, one for the consultant and one for the consultee, were developed for the use of the interviewer during the site visit. Semi-structured and open-ended questions, derived from concepts about the theory and practice of mental health consultation, were used in addition to highly structured questions relating to important identifying data. Questions were pre-tested on a sample of subjects drawn from the Los Angeles area. Both the questionnaire

for the consultant and the questionnaire for the consultee went through five revisions before final acceptance. The staff of the National Institute of Mental Health contributed significantly to the development of the questionnaires and collaborated in their revision. The two questionnaires used during the site visits are found in Appendices A and B. Specific content areas covered by the questionnaires included: establishing the consulting relationship, the nature of consultation services, the goals of consultation, the role perceptions of the consultant and consultee, techniques for evaluating consultation, and future directions and plans of the consultant and consultee.

SITE VISIT

Each site was visited for a minimum of two and a maximum of three days. The number of consultants and consultees made available by the site determined the length of the visit. In each instance, two trained and experienced staff members from Behavior Science Corporation with doctorates in psychology conducted the interviews. The interview schedule was determined by the individual site director although every effort was made to sample the widest possible range of professional background, responsibilities, and experience for both the consultants interviewed and the consultees. The nature and amount of data to be gathered required two hours to be allocated to each consultant interviewed and one hour to each consultee.

DATA ANALYSIS

The data gathered during the interviews were coded and analyzed by site. Trained coders were used in the coding phase of the procedure. The coded data were then punched into IBM cards for sorting and frequency tabulation. Frequency tables of pertinent data are found in those sections of the report to which they are related. Summary reports from each site were prepared from these data, and the total were subsequently reduced and collated. Empirical models representative of different types of consultation were then generated.

SUBJECTS

Interviewed were only those consultants and consultees who were directly, but not necessarily exclusively, involved with programs dealing with children under the age of 18. An attempt was made to interview up to ten consultants and consultees at each site. Any professional personnel involved in programs of research on consultation were also interviewed. Although the design of the study did not require that only those consultees be interviewed whose consultants could also be interviewed, at some sites this restriction was imposed on the interview schedule by the site administrator.

Eighty-eight consultants were scheduled for interviews. Eighty-five of these interviews were used in the compilation of data. One consultant was excluded from the data summary because he was providing supervision for another consultant and not consultation. Two consultants were not interviewed because of illness. Table 1 reflects a breakdown of consultants by site and professional background. Forty-six physicians were interviewed including 43 psychiatrists and three psychiatric fellows. Sixteen psychologists and 20 psychiatric social workers were interviewed. Thirteen of the psychologists held the doctorate and three the master's degree. All the social workers possessed the MSW degree. One of the consultants with a graduate degree in nursing and additional training in psychiatric nursing and public health was interviewed and is classified as "other mental health professional." The remaining two consultants interviewed did not regard themselves as mental health professionals. One of these holds a doctorate in family-life education and the other a baccalaureate degree in psychology.

Ninety-two consultees were interviewed. Eighty-nine of these interviews were used in the compilation of the data. Of the three consultees excluded from the data summary, two had not yet begun consultation. Their data were used only insofar as they provided information unique to the initiation of consultation. The third consultee was excluded because he appeared in the interview schedule by administrative error. His activities did not include providing services to children.

Table 2 reflects a breakdown of consultees by site and program of the consultee agency. Forty-seven consultees were involved in educational programs, six in courts and probation, 21 in public or private welfare agencies, three in other mental health facilities (e.g. family serv-

ice or mental health clinics), three in other community programs, three in public health agencies, and six in hospitals.

Table 3 describes the consultees by site and by level of administrative responsibility. Twenty-five consultees had exclusive or primary administrative responsibility for their programs. Nineteen consultees had primarily technical responsibilities within their agencies, and 45 consultees were considered to have both technical and administrative responsibilities as part of their job requirements.

Table 1 — CONSULTANTS BY SITE LOCATION AND PROFESSIONAL BACKGROUND

Professional Background	Los Angeles	San Mateo	Wood-lawn	Grand Rapids	Seattle	Colo-rado	New York	Phila-delphia	Prairie View	Mennin-ger	Totals
Psychiatrist	5	4	3		7	4	7	7	1	5	43
Psychiatric Fellow					2		1				3
Psychologist	5	3				5	1	1	1		16
Social Worker	1	3	1	4	2	5		2	2		20
Psychiatric Nurse									1		1
Others			1						1		2
Totals	11	10	5	4	11	14	9	10	6	5	85

Table 2 — CONSULTEES BY SITE LOCATION AND PROGRAM TYPE

Program Type	Los Angeles	San Mateo	Wood-lawn	Grand Rapids	Seattle	Colo-rado	New York	Phila-delphia	Prairie View	Mennin-ger	Totals
Educational Programs	13	5	5	3	7	3	2	4	1	4	47
Courts and Probation		1			2				2	1	6
Public and Private Welfare Agencies		2		8		1			5	5	21
Other Mental Health Facilities								2		1	3
Other Community Programs			1					1	1		3
Public Health Agencies									1	2	3
Hospitals							1	3		2	6
Totals	13	8	6	11	9	4	3	10	10	15	89

Table 3 — CONSULTEES BY SITE LOCATION AND ADMINISTRATIVE RESPONSIBILITY

Administrative Responsibility	Los Angeles	San Mateo	Wood-lawn	Grand Rapids	Seattle	Colo-rado	New York	Phila-delphia	Prairie View	Mennin-ger	Totals
Executive/Administrative	3	3	2	3	3	1		1	4	5	25
Line Worker	1	2	2	2	2	1		2	4	3	19
Both Executive/Administrative and Line Worker	9	3	2	6	4	2	3	7	2	7	45
Totals	13	8	6	11	9	4	3	10	10	15	89

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Chapter IV

A Conceptual Model for the Analysis of Mental Health Consultation

INTRODUCTION

Eighteen mental health facilities, located in ten sites throughout the country, were visited during the course of this study. All facilities offered mental health consultation to community agencies providing services to children. Structured and open-end questionnaires were used as a basis for interviews with a total of 178 persons participating in consultation. Of the 178 interviews, 86 were obtained from consultants and 92 from consultees. Data from 174 of these 178 interviews serve as the basis for the conceptual model presented in this chapter.

Mental health consultation activities observed during this study included a wide variety of procedures, many of which were conducted in a style unique to the individual professional. Among the practices subsumed under the heading of consultation were such diverse activities as direct service to consultee's clients, supervision, education, and therapy to consultees, as well as variations of the specific forms of consultation described in the literature. Confronted with the task of describing such a multitude of seemingly unique events, it became necessary to find a frame of reference which would order these events in meaningful ways.

The conceptual model described by Caplan and reviewed in Chapter II of this report was considered for use as a framework. However, examination of the data collected for this study revealed several programs which could not easily be categorized within his four consultation types. Three characteristics of Caplan's model precluded its applicability to these empirical data. First, his four types of consultation depend for their definition primarily on the content of the consultation session. However, it was our observation that the procedures for establishing the consultation relationship and the philosophy and goals of the consultant were no less important than the session content in categorizing types of consultation practice.

A second factor which required modification of Caplan's model was the assumption that it is the consultee agency which initiates the relationship with the mental health professional for the purpose of seeking help with their current client or program problems. Contrary to this assumption, particularly in those programs dealing with impoverished or disadvantaged populations, many of the consultation activities observed were initiated by the consultant actively promoting his services to consultee agencies or community groups. This approach to the initiation of consultation was felt to be necessary in order to reach large segments of the community who normally never seek out the mental health professional.

A third restriction to the use of the Caplan model is its requirement that the intra-personal and inter-personal processes of the consultee should be dealt with by the consultant only indirectly, if at all. Nevertheless, many consultation programs observed in this study have the personal processes of the consultees as their central focus. For this reason, descriptions of these programs would have been incomplete or distorted if forced into the Caplan framework.

These limitations of the best-known available model of consultation made it apparent that, for this study, a new conceptualization would have to be generated which could be descriptive of the full range of programs observed. As a result of an analysis of the data independent of prior theoretical commitment, patterns were uncovered sufficiently consistent to permit the gener-

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ation of a conceptual scheme containing descriptions of seven types of mental health consultation rather than four.

DEFINITIONS

For the purpose of this study, mental health consultation is defined as follows:

> A communication process between a mental health professional and an independent person, group, or institution (consultee), designed ultimately to benefit clients of the consultee.

This definition of consultation permits the term *direct services* to be reserved for those activities of a mental health professional wherein his sole purpose is to provide assistance to a child through his own personal contact, even when that contact takes place in a consultee agency. The term *supervision*, as differentiated from *consultation* and *direct services*, is appropriate only when the mental health professional has administrative responsibility for the actions of the mental health or non-mental health worker to whom he is relating. Other activities, such as teaching, collaboration, administrative manipulation, and mediation are included under one or more of the first five types of consultation to be delineated by this conceptual model.

THE CONCEPTUAL MODEL

Seven types of consultation have been defined which are mutually exclusive and exhaustive of the activities observed in the course of this study, excepting only those activities more properly called direct services or supervision. Examples of all of the first six types of consultation were observed at one or more of the sites visited. Type VI Consultation, however, was not thoroughly investigated as it describes consultation programs not directed to child services. Nevertheless, a full description of Type VI Consultation is included in this model, as is a projected definition for Type VII Consultation. Definitions of these additional types of consultation derive logically from an extrapolation of the parameters dealing with the identity of the consultee, the nature of the problems being considered, and the scope of the programs generated from the consultative effort. With extension to seven types, the conceptual model covers all possible consultation activities of mental health professionals. It is the opinion of the study team that consultation programs properly labeled Type VI and Type VII are currently in early stages of development and through the use of behavioral science specialists will soon make significant contributions to urban and social planning on a national and international scale.

Definitions for the seven types of consultation representing this conceptual model are as follows:

- Type I. *Client-Centered Clinical Case Conference Consultation*

This type of consultation is directly parallel to the traditional medical consultation model. That model focuses the consultation session with the consultees on a discussion of the client's problems, for purposes of diagnosis, treatment, and case disposition.

- Type II. *Client-Centered Staff Development Consultation*

This type of consultation uses a discussion of the client of the consultee for the purpose of staff development and training. A consultation session may include skill-building and information-sharing, personal growth and development (client-centered), and didactic in-service training.

- Type III. *Agency-Centered Staff Development Consultation*

This type of consultation focuses on the intra-personal and inter-personal problems within an agency. Peer, subordinate, supervisory, and extra-agency relationships may be discussed. Consultation may be provided to both administration and staff with the specific goal of personal growth and development which will permit the optimum realization of the agency's mission. Consultation techniques may include skill-building and information-sharing, personal growth and development (agency-centered), or personal enhancement through in-service training.

- Type IV. *Agency-Centered Program Development Consultation*

This type of consultation focuses on aiding the administration of an agency in originating, planning, and implementing programs which the agency desires to conduct within the community.

- Type V. *Community-Centered Mental Health Consultation*

This type of consultation is usually offered to broad community commissions and boards

whose purpose it is to plan the future directions of mental health activities in the community.

- Type VI. *Community-Centered Behavioral Science Consultation*

This type of consultation is usually offered to community and governmental organizations for the development of non-mental health facilities, plans, and programs which have a broad impact beyond the specific mental health area. Examples of these programs include:

a. public transportation systems
b. urban renewal projects
c. future development of school systems
d. police-community liaison
e. inter-agency relationships on a governmental level

- Type VII. *Behavioral Science Consultation on National and International Problems*

This type of consultation utilizes the expertise unique to the mental health professional in his capacity as a scientist trained in the area of human behavior. It is applied to the resolution of problems and the generation of decisions in those areas of broad social concern having a national or international impact.

In developing this conceptual model for mental health consultation it was necessary to derive from the data a group of parameters which would accurately and thoroughly describe the techniques and philosophy of every type of consultation observed and would differentiate each type from every other type. Wherever applicable, the parameters were focused on characteristics which could be described by behavioral observations, thereby providing operational definitions of maximum objectivity. The 18 parameters in the form of questions are listed below:

1. Are consultation sessions systematically scheduled?
2. How frequently are consultation sessions conducted?
3. How long a time period is allocated for consultation?
4. Where does the consultant meet with the consultee(s)?
5. Does the consultant typically have direct contact with the consultee's client?
6. Does the consultant assume any responsibility for diagnosis, treatment, or disposition of the consultee's client?
7. Are consultation sessions confined to an individual consultee?
8. Are consultation sessions confined to consultees from a single agency?
9. Are consultation sessions confined to consultees of one administrative level?
10. What professional background and training is necessary for the consultant?
11. Is it necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies?
12. Is it necessary for the consultant to have familiarity with the personal-social forces within a given agency or among various agencies?
13. Is it necessary for the consultant to have familiarity with the professional areas of the consultee?
14. What is the status relationship maintained by the consultant with the consultee?
15. To whom is the consultant ultimately responsible in the course of his consultation?
16. Does the consultant work toward termination of consultation?
17. What criteria are used to measure the effectiveness of consultation?
18. How are the intra-personal and interpersonal processes of the consultee explored during the consultation session?

An examination of the data generated by the 178 interviews conducted for this report permitted generalizations to be made regarding the patterns of behaviors typical of each of the first five types of consultation. These patterns, representing ideal types, are described at the end of this chapter, using the 18 parameters detailed for that purpose. The pattern described for Type VI is postulated for future validation or modification as further research dictates. Two arrangements are presented for the convenience of the reader. First, the 18 parameters are grouped by type of consultation providing an operational definition for each of the first six types of consultation. Second, the types of consultation are distributed along each of the 18 parameters. This latter grouping depicts the changes in each parameter as the types of consultation become more complex.

These descriptive statements represent an idealized standard against which to compare any individual consultation program. A consultation effort may deviate from the model on any one of several parameters and yet remain classifiable as a unique example of that one type of consultation. However, if the program deviates from the model on certain critical parameters it is immediately apparent that the program must be

reclassified under a type of consultation consistent with the behavior observed.

The parameters judged to be definitive, rather than descriptive, are:

5. Does the consultant typically have direct contact with the consultee's client?

6. Does the consultant assume any responsibility for diagnosis, treatment, or disposition of the consultee's client?

15. To whom is the consultant ultimately responsible in the course of his consultation?

18. How are the intra-personal and interpersonal processes of the consultee explored during the consultation session?

As is demonstrated below, contact with the client, the degree and direction of the consultant's responsibility, and the way in which the personal processes of the consultee are handled are the aspects of the consultant's behavior critical for determining which type of consultation is being practiced. Illustrated below are examples of the facility with which any type of consultation can be differentiated from any other by use of these parameters.

- Parameter 5. The amount of contact between the consultant and the consultee's client separates Type I and Type II from all other types.
- Parameter 6. The consultant's responsibility for consultee's client, separates Type I from Type II.
- Parameter 15. The direction of ultimate responsibility assigned by the consultant separates Types III and IV from other types of consultation in that the consultee agency remains the object to whom the consultant is responsible.
- Parameter 18. The way in which the consultants handle the personal processes of the consultee separates Type III from all other types.
- Parameter 15. This also demarks Types V and VI as those types of consultation wherein the consultant is ultimately responsible to the community at large. Furthermore, Type V is distinguishable from Type VI consultation primarily by the nature of the program (mental health vs. non-mental health).

The remaining 14 parameters, although not individually definitive, provide an exhaustive description of the relevant variables which determine how consultation will be carried out. When these variables are explicitly stated in advance, and adhered to in practice, the consultant can behave consistently within his own and his agency's goals. If circumstances require deviation, such deviations can take place in a knowledgeable and systematic way. In this fashion, those practices and procedures of consultation which are more a reflection of the individual consultant or the demands of the consultee agency can be minimized and the philosophy of the consultant agency and the nature of the consultation contract can be the determinants of consultation practice. Furthermore, instruments descriptive of consultation which are objective and reliable are necessary for the experimental investigation of the consultation process. Such investigations, particularly in the area of the effectiveness of consultation, are among those most needed. These parameters, providing descriptive instruments, make research into the evaluation of consultation techniques closer to realization.

SUMMARY AND DISCUSSION

A conceptual model was derived from an analysis of data from interviews with 86 mental health consultants and 92 consultees. This model contains definitions for seven types of mental health consultation. In addition, 18 parameters descriptive of six of the seven types are presented as a structure for observations which permit an objective behavioral basis for classification of all current consultation activities into one of the six types described.

The utility of this conceptual model derives particularly from two attributes. First, it is specific in its description of those mechanics of consultation which characterize the different types of consultation. Because of this specificity, the model has a greater value as a guide for consultation training than do conceptual models which make only vague reference to or ignore the how-when-and-where details of consultation practices. Furthermore, during consultation training, a mental health professional can become acquainted with the philosophical issues raised when consultation is being performed and can question whether positions which were axiomatic within the traditional role of therapist-patient are approximate to his new consultant-consultee role. No presumption is made here that the ways in which these questions are answered by this conceptual model are either

"right" or the only answers possible. Perhaps the largest contribution the model may make to the field of mental health consultation will be in its ability to call attention to the necessity for the consultant to make explicit commitments to some position on these issues prior to engaging in consultation.

Second, the model can be used as a tool for descriptive and evaluative research. A greater level of objectivity and precision is made available (because of its basis in behavioral observations) than was possible using existing descriptive techniques depending largely on subjective judgments. The degree of detail with which the 18 parameters define the mechanics of each type of consultation provides a foundation for the type of controlled experimentation necessary to find definitive answers to questions important to advancing the usefulness of consultation.

Finally, the heuristic value of a conceptual model which is testable cannot be over-emphasized. Despite major efforts by a few theoreticians and training centers, the vast majority of mental health professionals currently offering consultation services follow procedures which are largely unsystematic, unplanned, and responsive primarily to the expediencies of the moment. The need for a comprehensive theory of the consultation process exceeds even the urgent need for more mental health services or more trained professionals. There can be neither research nor secure generalizations to teach new consultants until such a theory is generated in terms which permit experimental validation. Hopefully, the conceptual model proposed in this report is a step in that direction.

OPERATIONAL DEFINITIONS OF THE SIX TYPES OF CONSULTATION AS DESCRIBED BY THE EIGHTEEN PARAMETERS

Type I. Client-Centered Clinical Case Conference Consultation

This type of consultation is directly parallel to the traditional medical consultation model. That model focuses the consultation session on a discussion of the client's problems for purposes of diagnosis, treatment, and case disposition.

1. Consultation sessions are regularly scheduled.

2. Consultation sessions are scheduled once a week.

3. Consultation sessions are one to two hours in length.

4. Consultation sessions are typically held at a mutually agreed upon site which best serves the interests of the client. Frequently, sessions are conducted at the site of consultee's activity.

5. The consultant typically has contact with the consultee's client.

6. The consultant frequently shares or assumes responsibility for diagnosis, treatment, or disposition of the consultee's client.

7. Consultation sessions typically include more than one person from the consultee agency.

8. Consultation sessions are typically not confined to members of a single agency.

9. Consultation sessions are not confined to a single administrative level.

10. The consultant has participated and been exposed to this type of consultation during the course of his training as a mental health professional. Therefore, formal training in the theory and practices of consultation is not necessary.

11. It is useful for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

12. The consultant does not need to be familiar with the personal-social forces within a given agency.

13. It is helpful for the consultant to be acquainted with the professional areas of the consultees participating in the conference.

14. The consultant maintains the role of an authoritative expert contributing his knowledge for decision-making purposes.

15. Because the consultant is typically making decisions relating to diagnosis, treatment, and disposition, his primary responsibility is directed toward the welfare of the client.

16. The consultant works toward improving the skills of the agency staff in the direction of their increased independence for making diagnosis, treatment, and disposition decisions about the clients of the agency. However, he also works toward broadening his relationship with the agency so as to permit the introduction of other types of consultation.

17. The consultant would prefer to use changes in the behavior of the client (child) to assess the effectiveness of his consultation. However, in practice he relies on changes in the behavior of the consultee reflecting an increased appreciation of the value of consultation.

18. The intra-personal and inter-personal conflicts of the consultee are avoided when possible or discussed only indirectly.

Type II. Client-Centered Staff Development Consultation

This type of consultation uses a discussion of the client of the consultee for the purpose of staff development and training. A consultation session may include skill-building and information-sharing, personal growth and development (client-centered), and didactic in-service training.

1. Consultation sessions are regularly scheduled.
2. Consultation sessions may range in frequency from once a week to once a month.
3. Consultation sessions are from one to four hours in length.
4. Consultation sessions are typically held at the site of consultee's activity.
5. The consultant typically has no contact with the consultee's client.
6. The consultant assumes no direct responsibility for diagnosis, treatment, or disposition of the consultee's client.
7. Consultation sessions typically include more than one person from the consultee agency.
8. Consultation sessions are typically confined to members of a single agency.
9. Consultation sessions are typically confined to a single administrative level.
10. Formal training in the theory and practices of consultation is highly desirable but not mandatory. Training as a mental health professional is required.
11. It is desirable for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.
12. The consultant should be familiar with the personal-social forces within a given agency.
13. The consultant should be familiar with the professional area of the consultee.
14. The consultant maintains and encourages an authoritative status relationship which is both permissive and supportive of changes in the consultee's behavior in the direction of being more like the consultant.
15. When the consultant is confronted with a situation in which the interests of the consultee and client are in conflict, he will give priority to his responsibility to the client.
16. The consultant always works toward the termination of specific consultation programs but will encourage an open-ended relationship that permits the enlargement of his professional influence within the agency.
17. The consultant evaluates the effectiveness of his consultation by observing changes in the consultee's behavior in the direction of more competent, independent problem-solving.
18. The intra-personal and inter-personal conflicts of the consultee are discussed indirectly through the vehicle of the consultee's client.

Type III. Agency-Centered Staff Development Consultation

This type of consultation focuses on the intra-personal and inter-personal processes within an agency. Consultation may be provided to both administration and staff with the specific goals of personal growth, staff development, and the improvement of policies and procedures internal to the agency which will permit the optimum realization of the agency mission.

1. Consultation sessions are regularly scheduled.
2. Consultation sessions may vary from once a week to once a month.
3. Consultation sessions are from one hour to a full day in length.
4. Consultation sessions are typically held at the site of consultee's agency.
5. The consultant never has contact with the agency's clients.
6. The consultant assumes no responsibility for the agency's clients in regard to diagnosis, treatment, or disposition.
7. Two patterns of consultation are observed in this type of consultation:
   a. Individual meetings with the director are held, during which staff and agency problems are discussed and programs for their improvement are worked out.
   b. Groups of agency personnel meet in consultation sessions which focus on intra-agency goals, staff development and information-sharing, or a discussion of staff interactions aimed at personal growth.
8. Consultation sessions are typically confined to consultees from a single agency.
9. Consultation sessions are typically, but not necessarily, confined to consultees of the same administrative level.
10. Formal training and experience in the theory and practices of consultation as well as training in group dynamics is essential if the consultant is to be maximally effective. Training as a mental health professional is required.
11. It is necessary for the consultant to have

familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

12. The consultant must be familiar with all the peer, superior, and subordinate personal-social forces within the consultee agency.

13. The consultant must be familiar with the professional area of the administrator and staff of the agency.

14. The consultant must maintain an authoritative status relationship with the administrator and staff of the agency which supports his position as an expert. This relationship, however, must also encourage openness and permit the personal feelings of the consultee to be discussed in a problem-solving atmosphere.

15. When the consultant is confronted with a situation in which the interests of the individual consultee and the consultee agency are in conflict, he will give priority to his responsibility to the agency.

16. The consultant always works toward the termination of specific consultation programs but will encourage an open-ended relationship that permits the enlargement of his professional influence within the agency.

17. The consultant evaluates the effectiveness of his consultation by observing and evaluating the nature of the changes in the functioning of the staff of the consultee agency.

18. The inter-personal and intra-personal processes of the agency staff are appropriate topics for direct discussion during consultation.

Type IV. Agency-Centered Program Development Consultation

This type of consultation focuses on aiding the administration of the agency in originating, planning, and implementing programs which the agency desires to conduct within the community.

1. Consultation sessions are usually regularly scheduled.

2. There may be several patterns of frequency of scheduled contact ranging from daily to monthly.

3. No less than a half day is allocated for a consultation session and frequently a full day may be allocated.

4. Consultation sessions are typically held at the site of consultee's agency.

5. The consultant never has contact with the agency's clients.

6. The consultant assumes no responsibility for the agency's clients. He may, however, influence programs and policies which affect the agency's clients in regard to diagnosis, treatment, or disposition.

7. Consultation sessions may include more than one person from a consultee agency.

8. Consultation sessions are typically not confined to consultees of a single agency.

9. Consultation sessions are not necessarily confined to a single administrative level.

10. Formal training, with demonstrated expertise in the theory and practices of consultation, is necessary. Training as a mental health professional is required.

11. It is mandatory for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

12. The consultant must be familiar with the personal-social forces within a given agency as well as the personal-social forces in the community.

13. It is necessary for the consultant to have intimate knowledge of the professional area of the administrator and staff of the agency.

14. The consultant maintains a status relationship with the consultee which is dependent upon the consultant's expert knowledge rather than his authority.

15. When the consultant is confronted with a situation in which the interests of the agency and the professional role of the consultant are in conflict, his own personal and professional values and his responsibility to the community at large will have priority over his responsibility to the consultee agency.

16. The consultant always works toward the successful implementation of specific consultation programs but encourages an open-ended relationship that will permit him to influence the future programs of the agency.

17. The consultant evaluates the effectiveness of his consultation by observing and evaluating the nature of the changes in the operation of the consultee agency.

18. The consultant rarely, if ever, explores the intra-personal or inter-personal processes of the consultee except when necessary for the continued development of the agency program.

Type V. Community-Centered Mental Health Consultation

This type of consultation is usually offered to broad community commissions and boards whose purpose it is to plan the future directions of mental health activities in the community.

1. Consultation sessions are usually regularly scheduled.

2. The frequency of consultation meetings

may vary widely, but typically they are not more frequent than once per month.

3. Consultation meetings may range in length from half a day to several days.

4. Consultation meetings are held at times and places most convenient to members of the commission or board. Factors of status hierarchy play a role in selection of both time and place.

5. The consultant never has contact with the eventual recipients of care.

6. The consultant shares responsibility for the development of policies and programs in the mental health field which will influence the diagnosis, treatment, or disposition of clients receiving mental health services.

7. Consultation meetings rarely include more than one person from a consultee agency.

8. Consultation meetings are *never* confined to individuals from a single agency.

9. The individuals present at consultation meetings have varying administrative responsibilities within the community but not in relation to each other.

10. In addition to his training as a mental health professional the consultant must also have:

a. formal training and demonstrated expertise in mental health consultation,

b. a reputation of the highest order in his professional field,

c. expertise in a sub-specialty uniquely appropriate for the programs being considered.

11. It is necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within the community to be served by the programs being planned.

12. The consultant must have intimate knowledge of the personal-social forces operating within the agencies involved in the programs being considered. He also needs to be familiar with the personal-social forces operating within the catchment area of these programs.

13. The consultant may be required to have familiarity with and knowledge of the professional characteristics of the staff of all the agencies involved in program planning.

14. The consultant maintains a peer relationship as well as:

a. a mutual high level of respect for the knowledge and expertise of all individuals involved,

b. a continuing authority position due to his special knowledge applicable to the mental health programs being planned.

15. The consultant is responsible solely to the community.

16. The consultant does not work toward the termination of consultation but maintains his relationship to the board in order to continue as an active participant in the development of solutions for the changing mental health needs of the community. The consultant will also assist the board in planning policies. programs, and procedures that will permit the introduction of other types of consultation into the community which utilize more directly the skills of the mental health professional.

17. Changes in community mental health activities are the criteria used for evaluating effectiveness.

18. The intra-personal or inter-personal processes of the board members are never explored during the consultation meetings.

Type VI. Community-Centered Behavioral Science Consultation (Non-Mental Health)

This type of consultation is usually offered to community and governmental organizations for the development of non-mental health facilities, plans, and programs which have a broad impact beyond the specific mental health area to include:

a. public transportation systems,
b. urban renewal projects,
c. future development of school systems,
d. police-community liaison,
e. inter-agency relationship on a governmental level.

1. Consultation meetings may be regularly scheduled but are most typically ad hoc.

2. The frequency of consultation meetings varies widely.

3. Consultation meetings may vary widely in length.

4. Consultation meetings are held at times and places of most convenience to members of the commission or board. Factors of status hierarchy play a determining role in selection of both time and place.

5. The consultant never has contact with the eventual consumer.

6. The consultant shares responsibility for the development of community policies and programs that will influence the nature of the services received by the consumer unrelated to the mental health activities of diagnosis, treatment, or disposition of patients.

7. Consultation meetings rarely include more than one person from one agency.

8. Consultation meetings are never confined to individuals from a single agency.

9. The individuals present at consultation meetings have varying administrative responsibilities within the community but not in relation to each other.

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10. Formal training and demonstrated expertise as a mental health consultant permits recognition as an authority in the field of human behavior. However, the consultant must also be expert in areas of behavioral science other than clinical practice.

11. It is necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within the community to be served by the programs being planned.

12. The consultant must have broad knowledge of the personal-social forces extant in the catchment area of the programs being planned.

13. The consultant must be familiar with the professional areas of the other specialists involved in the planning or implementation of the programs being considered.

14. The consultant functions as an equal contributor among peers.

15. The consultant is responsible solely to the community.

16. The consultant does not work toward the termination of consultation but maintains his relationship with existing political structures within the community so as to exert his influence toward the utilization of those behavioral science principles judged most conducive to the development of a mentally healthy people.

17. The criteria used for evaluating the effectiveness of consultation are not only related to the solution of current problems and crises but to the development of those programs which have as their goal the general advancement of the human condition.

18. The intra-personal or inter-personal processes of the board members are never explored during the consultation meetings.

DISTRIBUTION OF ANSWERS TO THE EIGHTEEN DESCRIPTIVE QUESTIONS BY TYPE OF CONSULTATION

1. Are Consultation Sessions Systematically Scheduled?

Type I. Consultation sessions are regularly scheduled.

Type II. Consultation sessions are regularly scheduled.

Type III. Consultation sessions are regularly scheduled.

Type IV. Consultation sessions are usually regularly scheduled.

Type V. Consultation meetings may be regularly scheduled but are most typically ad hoc.

Type VI. Consultation meetings may be regularly scheduled but are most typically ad hoc.

This variable is distributed in a bipolar fashion as follows:

Type I	Regularly scheduled sessions
	or
Type VI	Ad hoc sessions.

2. How Frequently Are Consultation Sessions Conducted?

Type I. Consultation sessions are scheduled once a week.

Type II. Consultation sessions may range in frequency from once a week to once a month.

Type III. Consultation sessions may vary from once a week to once a month.

Type IV. There may be several patterns of frequency of scheduled contact ranging from daily to monthly.

Type V. The frequency of consultation meetings may vary widely, but typically they are not more frequent than once per month.

Type VI. The frequency of consultation meetings varies widely.

This variable is distributed in a linear fashion ranging from:

Type I	One session per week
	to
Type VI	Less than one session per month.

3. How Long a Time Period Is Allocated for Consultation?

Type I. Consultation sessions are one to two hours in length.

Type II. Consultation sessions are from one to four hours in length.

Type III. Consultation sessions are from one to a full day in length.

Type IV. No less than a half day is allocated for a consultation session, and frequently a full day may be allocated.

Type V. Consultation meetings may range in length from half a day to several days.

Type VI. Consultation meetings may vary widely in length.

This variable is distributed in a linear fashion ranging from:

Type I	One hour per session
	to
Type VI	Several days per session.

4. Where Does the Consultant Meet With the Consultee(s)?

Type I. Consultation sessions are typically held at a mutually agreed upon site which best serves the interests of the client. Frequently, sessions are conducted at the site of consultee's activity.

Type II. Consultation sessions are typically held at the site of consultee's activity.

Type III. Consultation sessions are typically held at the site of consultee's agency.

Type IV. Consultation sessions are typically held at the site of consultee's agency.

Type V. Consultation meetings are held at times and places most convenient to members of the commission or board. Factors of status hierarchy play a role in selection of both time and place.

Type VI. Consultation meetings are held at times and places of most convenience to members of the commission or board. Factors of status hierarchy play a determining role in selection of both time and place.

This variable is distributed in a bipolar fashion as follows:

Types I, II, III, and IV	Sessions are held at the site of the consultee's activity
	or
Types V and VI	Sessions are held at various community facilities determined by the group.

5. Does the Consultant Typically Have Direct Contact With the Consultee's Client?

Type I. The consultant typically has contact with the consultee's client.

Type II. The consultant typically has no contact with the consultee's client.

Type III. The consultant never has contact with the agency's clients.

Type IV. The consultant never has contact with the agency's clients.

Type V. The consultant never has contact with the eventual recipients of care.

Type VI. The consultant never has contact with the eventual consumer.

This variable is distributed in a bipolar fashion as follows:

Type I	The consultant typically has contact with the client of the consultee
	or
Types II, III, V, and VI	The consultant typically has no contact with the eventual consumers of service.

6. Does the Consultant Assume Any Responsibility for Diagnosis, Treatment, or Disposition of the Consultee's Client?

Type I. The consultant frequently shares or assumes responsibility for diagnosis, treatment, or disposition of the consultee's client.

Type II. The consultant assumes no direct responsibility for diagnosis, treatment, or disposition of the consultee's client.

Type III. The consultant assumes no responsibility for the agency's clients in regard to diagnosis, treatment, or disposition.

Type IV. The consultant assumes no responsibility for the agency's clients. He may, however, influence programs and policies which affect the agency's clients in regard to diagnosis, treatment, or disposition.

Type V. The consultant shares responsibility for the development of policies and programs in the mental health field which will influence the diagnosis, treatment, or disposition of the clients receiving mental health services.

Type VI. The consultant shares responsibility for the development of community policies and programs that will influence the nature of the services received by the consumer unrelated to the mental health activities of diagnosis, treatment, or disposition of patients.

This variable is distributed in a nonlinear fashion as follows:

Types I and V	The consultant shares or assumes some responsibility for diagnosis, treatment, or disposition.
Types II and III	The consultant assumes no direct responsibility for diagnosis, treatment, or disposition.
Type IV	The consultant influences the eventual diagnosis, treatment, and disposition of the agency's clients without direct responsibility.
Type VI	Responsibility for diagnosis, treatment, and disposition is irrelevant

to this type of consultation.

7. Do Consultation Sessions Typically Include More Than One Person From the Consultee Agency?

Type I. Consultation sessions typically include more than one person from the consultee agency.

Type II. Consultation sessions typically include more than one person from the consultee agency.

Type III. Two patterns are observed in this type of consultation:

a. Individual meetings with the director are held during which staff problems are discussed and programs for their improvement are worked out.

b. Groups of agency personnel meet in consultation sessions which focus on intra-agency goals, staff development and information-sharing, structured in-service training, or a discussion of staff interactions aimed at personal growth.

Type IV. Consultation sessions may include more than one person from a consultee agency.

Type V. Consultation meetings rarely include more than one person from one agency.

Type VI. Consultation meetings rarely include more than one person from one agency.

This variable is distributed in a bipolar fashion as follows:

Types I, II, III, and IV	The sessions typically include more than one person from the consultee agency
	or
Types V and VI	The meetings rarely include more than one person from the agency.

8. Are Consultation Sessions Confined to Consultees From a Single Agency?

Type I. Consultation sessions are typically not confined to members of a single agency.

Type II. Consultation sessions are typically confined to members of a single agency.

Type III. Consultation sessions are typically confined to consultees from a single agency.

Type IV. Consultation sessions are typically not confined to consultees of a single agency.

Type V. Consultation meetings are *never* confined to individuals from a single agency.

Type VI. Consultation meetings are never confined to individuals from a single agency.

This variable is distributed in a nonlinear fashion as follows:

Types I and IV	Sessions are typically not confined to consultees from a single agency.
Types II and III	Sessions are typically confined to consultees from a single agency.
Types V and VI	Meetings are never confined to personnel from a single agency.

9. Are Consultation Sessions Confined to Consultees of One Administrative Level?

Type I. Consultation sessions are not confined to a single administrative level.

Type II. Consultation sessions are typically confined to a single administrative level.

Type III. Consultation sessions are typically, but not necessarily, confined to consultees of the same administrative level.

Type IV. Consultation sessions are not necessarily confined to a single administrative level.

Type V. The individuals present at consultation meetings have varying administrative responsibilities within the community but not in relation to each other.

Type VI. The individuals present at consultation meetings have varying administrative responsibilities within the community but not in relation to each other.

This variable is distributed in a nonlinear fashion as follows:

Types I and IV	Sessions are not confined to consultees of one administrative level.
Types II and III	Sessions are typically confined to consultees of one administrative level.
Types V and VI	The consultees do not typically have an administrative relationship to each other.

10. What Professional Background and Training Is Necessary For the Consultant?

Type I. The consultant has participated and been exposed to this type of consultation during the course of his training as a mental health professional. However, formal training in the theory and practices of consultation is not necessary.

Type II. Formal training in the theory and practices of consultation is highly desirable but not mandatory. Training as a mental health professional is required.

Type III. Formal training and experience in the theory and practices of consultation as well as training in group dynamics is essential if the consultant is to be maximally effective. Training as a mental health professional is required.

Type IV. Formal training with demonstrated expertise in the theory and practices of consultation is necessary. Training as a mental health professional is required.

Type V. In addition to his training as a mental health professional the consultant must also have:

a. Formal training and demonstrated expertise in mental health consultation.

b. A reputation of the highest order in his professional field.

c. Expertise in a sub-specialty uniquely appropriate for the programs being considered.

Type VI. Formal training and demonstrated expertise as a mental health consultant permits recognition as an authority in the field of human behavior. However, the consultant must also be expert in areas of behavorial science other than clinical practice.

This variable is distributed in a linear fashion ranging from:

Type I	Training as a mental health professional only
to	
Type VI	Formal training and demonstrated expertise as a mental health consultant as well as having expert knowledge in areas of behavioral science other than clinical practice.

11. Is It Necessary for the Consultant To Have Familiarity With the Administrative, Political, and Legal Policies and Procedures Within a Given Agency or Among Various Agencies?

Type I. It is useful for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

Type II. It is desirable for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

Type III. It is necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

Type IV. It is mandatory for the consultant to have familiarity with the administrative, political, and legal policies and procedures within a given agency or among various agencies.

Type V. It is necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within the community being served by the programs being planned.

Type VI. It is necessary for the consultant to have familiarity with the administrative, political, and legal policies and procedures within the community being served by the programs being planned.

This variable is distributed in a bipolar fashion as follows:

Types I, II, and IV	The consultant needs to have familiarity with the policies within an *agency*
or	
Types V and VI	The consultant needs to have familiarity with various political and agency policies within a *community*.

12. Is It Necessary for the Consultant To Have Familiarity With the Personal-Social Forces Within a Given Agency or Among Various Agencies?

Type I. The consultant does not need to be familiar with the personal-social forces within a given agency.

Type II. The consultant should be familiar with the personal-social forces within a given agency.

Type III. The consultant must be familiar with all the peer, superior, and subordinate personal-social forces within the consultee agency.

Type IV. The consultant must be familiar with the personal-social forces within a given agency as well as the personal-social forces in the community.

Type V. The consultant must have intimate knowledge of the personal-social forces operating within the agencies involved in the programs being considered. He also needs to be familiar with the personal-social forces operating within the catchment area of these programs.

Type VI. The consultant must have broad knowledge of the personal-social forces extant in the catchment area of the programs being planned.

This variable is distributed in a linear fashion ranging from:

Type I — No familiarity with the personal-social forces

to

Type VI — The broadest range of familiarity with the personal-social forces occurring within a large geographic area.

13. Is It Necessary for the Consultant To Have Familiarity With the Professional Area of the Consultee?

Type I. It is helpful for the consultant to be acquainted with the professional areas of the consultees participating in the conference.

Type II. The consultant should be familiar with the professional area of the consultee.

Type III. The consultant must be familiar with the professional area of the administrator and staff of the agency.

Type IV. It is necessary for the consultant to have intimate knowledge of the professional area of the administrator and staff of the agency.

Type V. The consultant may be required to have familiarity with and knowledge of the professional characteristics of the staff of all of the agencies involved in program planning.

Type VI. The consultant must be familiar with the professional areas of the other specialists involved in the planning or implementation of the programs being considered.

This variable is distributed in a linear fashion ranging from:

Type I — Knowledge by the consultant of the consultee's professional area

to

Type VI — Broad knowledge by the consultant of several professional areas.

14. What Is the Status Relationship Maintained by the Consultant With the Consultee?

Type I. The consultant maintains the role of an authoritative expert contributing his knowledge for decision-making purposes.

Type II. The consultant maintains and encourages an authoritative status relationship which is both permissive and supportive of changes in the consultee's behavior in the direction of being more like the consultant.

Type III. The consultant must maintain an authoritative status relationship with the administrator and staff of the agency which supports his position as an expert. This relationship, however, must also encourage openness and permit the personal feelings of the consultee to be discussed in a problem-solving atmosphere.

Type IV. The consultant maintains a status relationship with the consultee which is determined by the consultant's expert knowledge rather than his authority.

Type V. The consultant maintains a peer relationship as well as:

a. A mutual high level of respect for the knowledge and expertise of all individuals involved.

b. A continuing authority position due to his special knowledge applicable to the mental health programs being planned.

Type VI. The consultant functions as an equal contributor among peers.

This variable is distributed in a linear fashion ranging from:

Type I — Acceptance by the consultant of an authoritative status relationship

to

Type VI — Acceptance by the consultant of a peer status relationship.

15. To Whom Is the Consultant Ultimately Responsible in the Course of His Consultation?

Type I. Because the consultant is typically

making decisions relating to diagnosis, treatment, and disposition, his primary responsibility is directed to the welfare of the client.

Type II. When the consultant is confronted with a situation in which the interests of the consultee and client are in conflict, he will give priority to his responsibility to the client.

Type III. When the consultant is confronted with a situation in which the interests of the individual consultee and the consultee agency are in conflict, he will give priority to his responsibility to the agency.

Type IV. When the consultant is confronted with a situation in which the interests of the agency and the professional role of the consultant are in conflict, his own personal and professional values and his responsibility to the community at large will have priority over his responsibility to the consultee agency.

Type V. The consultant is responsible solely to the community.

Type VI. The consultant is responsible solely to the community.

This variable is distributed in a linear fashion ranging from:

Type I — Responsibility of the consultant to an individual client

to

Type VI — Responsibility of the consultant to all members of the community.

16. Does the Consultant Work Toward Termination of Consultation?

Type I. The consultant works toward improving the skills of the agency staff in the direction of their increased independence for making diagnosis, treatment, and disposition decisions about the clients of the agency. However, he also works toward broadening his relationship with the agency so as to permit the introduction of other types of consultation.

Type II. The consultant always works toward the termination of specific consultation programs but will encourage an open-ended relationship that permits the enlargement of his professional influence within the agency.

Type III. The consultant always works toward the termination of specific consultation programs but will encourage an open-ended relationship that permits the enlargement of his professional influence within the agency.

Type IV. The consultant always works toward the successful implementation of specific consultation programs but encourages an open-ended relationship that will permit him to influence the future programs of the agency.

Type V. The consultant does not work toward the termination of consultation but maintains his relationship to the board in order to continue as an active participant in the development of solutions for the changing mental health needs of the community. The consultant will also assist the board in planning policies, programs, and procedures that will permit the introduction of other types of consultation into the community which utilize more directly the skills of the mental health professional.

Type VI. The consultant does not work toward the termination of consultation but maintains his relationship with existing political structures within the community so as to exert his influence toward the utilization of those behavior science principles judged most conducive to the development of a mentally healthy people.

Types of consultation are not distributed along the dimension of termination of the consulting relationship. Consultant agencies, regardless of the type of consultation being provided, attempt to continue the consulting relationship although the character of that relationship may change.

17. What Criteria Are Used To Define the Goals or To Measure the Effectiveness of Consultation?

Type I. The consultant would prefer to use changes in the behavior of the client (child) to assess the effectiveness of his consultation. However, in practice he relies on changes in the behavior of the consultee reflecting an increased appreciation of the value of consultation.

Type II. The consultant evaluates the effectiveness of his consultation by observing changes in the consultee's behavior in the direction of more competent, independent problem-solving.

Type III. The consultant evaluates the effectiveness of his consultation by observing and evaluating the nature of the changes in the functioning of the staff of the consultee agency.

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Type IV. The consultant evaluates the effectiveness of his consultation by observing and evaluating the nature of the changes in the operation of the consultee agency.

Type V. Changes in community mental health activities are the criteria used for evaluating effectiveness.

Type VI. The criteria used for evaluating the effectiveness of consultation are not only related to the solution of current problems and crises but to the development of those programs which have as their goal the general advancement of the human condition.

This variable is distributed in a linear fashion ranging from:

Type I	Evaluation of effectiveness by the change in the behavior of a single child or consultee
to	
Type VI	Evaluation of effectiveness by the changes in programs touching the daily lives of everyone.

18. How Are the Intra-personal and inter-personal Processes of the Consultee Explored During the Consultation Session?

Type I. The intra-personal and inter-personal processes of the consultee are avoided when possible or discussed only indirectly.

Type II. The intra-personal and inter-personal processes of the consultee are discussed indirectly through the vehicle of the consultee's client.

Type III. The intra-personal and inter-personal processes of the agency staff are appropriate topics for direct discussion during consultation.

Type IV. The Consultant rarely, if ever, explores the intra-personal or inter-personal processes of the consultee except when necessary for the continued development of the agency program.

Type V. The intra-personal and inter-personal processes of the board members are never explored during the consultation meetings.

Type VI. The intra-personal and inter-personal processes of the board members are never explored during the consultation meetings.

This variable is distributed in a non-linear fashion as follows:

Type I	The consultant explores the personal conflicts of the consultee rarely, if at all.
Types II and III	The consultant *does* explore the personal conflicts of the consultee.
Types IV V, and VI	The consultant never explores the personal processes of the consultee.

Chapter V

Discussion and Analysis

INTRODUCTION

Eighteen mental health facilities located in ten sites throughout the country were visited in the course of this study. All of the facilities offer mental health consultation to community agencies providing services to children. Structured and open-end questionnaires were used as a basis for in-depth interviews with a total of 178 persons participating in consultation. Of these 178 interviews, 86 were obtained from consultants and 92 from consultees. Data from 174 of these interviews serve as the basis for the discussion and analysis of mental health consultation presented in this chapter. The data from four interviews were not analyzed for reasons described previously in Chapter III.

It would not be appropriate to use these data as a basis for the evaluation or validation of the effectiveness of consultation. It was not the intent of the study to challenge the value of the participants' investment in mental health consultation but, rather, to discuss their perceptions, attitudes, expectations, and goals as variables important to an intensive analysis of the consultation process. As has been suggested by our conceptual model, efforts directed to the assessment of consultation must await the definition of objective criteria measures more reliable than the subjective judgments currently available.

The nature of the interviews also dictated an heuristic rather than a judgmental approach to the data. Furthermore, the questionnaires structured the interviews so as to be inclusive of the subjective opinions of the interviewee and, as a result, do not lend themselves to a level of precision that warrants quantitative conclusions.

For these reasons, this section of the report is not a quantitative analysis, nor are conclusions regarding the effectiveness of consultation presented. This chapter will, instead, offer a set of variables abstracted from the data which are intrepreted in terms of the general importance they may have for an understanding of consultation as a process. Factors discussed include the professional background and training of the participants, their views of the consultation contract, and their perceptions of relevant aspects of the consultation relationship. When the data permit, an interpretive analysis highlights the more important of these variables.

THE SITES AND THE PARTICIPANTS IN CONSULTATION

Facilities Providing Consultation

Of the 18 facilities visited, six are community mental health centers, four are hospitals, three are centers for professional training in consultation, two are county mental health departments, two are child guidance clinics, and one is a rural consultation program. The largest of these facilities has the responsibility for providing mental health services for 7,000,000 people; the smallest program described is that of a single consultant operating in a sparsely populated, rural mountain area. All of these programs are receiving partial or total financial support from the National Institute of Mental Health. They also include, as an integral part of their activities, mental health consultation to agencies providing services or having caretaking responsibilities for children.

Facilities Receiving Consultation

Facilities receiving consultation, from whom interviews with staff members were obtained, include:

- Educational programs; public and private nursery, elementary, and secondary schools;

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Head Start programs; and schools within residential treatment facilities

- Law-enforcement agencies; juvenile courts, probation departments, and juvenile detention centers
- Public and private welfare agencies
- Public health agencies
- General hospitals
- Community-action programs
- Other mental health facilities, such as the Family Service Agency, or adult mental health clinics

For the purposes of this study, the nature of the consultee agency was not considered critical to the understanding of the consultation process. Therefore no attempts were made to ensure the inclusion of a representative sampling of all types of care-giving facilities in this report. As a result, the administrators of the consultant agencies were allowed to select the consultee agencies to be sampled. To the extent that this sampling is more heavily loaded in the direction of one type of consultee agency rather than another, this loading is reflected in an increased number of consultee interviews from that particular agency type.

Personnel Providing Consultation

A total of 85 consultants were interviewed at the 18 consultant facilities visited. The number of consultants by professional background is listed below:

Mental Health Professionals

- Forty-six physicians, including 43 psychiatrists and three psychiatric fellows receiving training in consultation.
- Twenty psychiatric social workers, including 19 with the Master of Social Work degree and one with the Doctor of Social Work degree.
- Sixteen psychologists, including 13 with the doctorate and three with the master's degree.
- One graduate nurse with psychiatric training and public health experience.

Others

- One educator with a doctorate in family-life education.
- One community representative with a baccalaureate degree in psychology.

The disproportionate number of consultants with medical backgrounds is related to several factors. A large percentage of the facilities visited provide training in mental health consultation for psychiatrists, or the facility is an integral part of a total service program which includes psychiatric care and treatment. Historically and traditionally these activities, as well as the administrative responsibility for installations providing treatment services, have been the responsibility of the physician.

In order to explore the effect of the professional background of the consultant on the consultation process, data were gathered on the specific training of each of the three major mental health disciplines whose members were interviewed. An interpretation of these data with particular reference to the advantages and disadvantages of each type of professional training as preparation for the practice of consultation is presented in the following section.

The Psychiatrist-Consultant

Many of the physician-consultants interviewed report that certain aspects inherent in medical training may be detrimental to performing effectively as a consultant. Among the reasons cited are the difficulties experienced in shifting from the authoritative position the physician has been trained to assume in his relationship with patients, the medical focus on the dyadic therapy model to the exclusion of experience and knowledge of group processes, and the conceptual emphasis of the medical model on disease, rather than on the normal patterns of human behavior. These factors are felt to channel the physician-consultant into an orientation toward consultation which excludes recognition of social, cultural, and other ecological factors important to the consultation process.

Almost universally, the professionals doing consultation regard the extensive training of the psychiatrist in recognizing and understanding the dynamics of personality as a major asset for conducting all types of consultation. Physician-consultants also report that their experience in accepting responsibility, and in making crucial decisions, as well as the status role assigned to them by the culture, are characteristics of medical training which are advantageous to their functioning as consultants. However, these factors are relevant only to client-centered consultation (Types I and II), in which the consultant assumes or shares the responsibility for treatment and disposition decisions, and

they may even be restrictive when the consultation relationship is agency- or community-centered.

These consequences of medical training are recognized as important issues by those professionals responsible for formal training programs in mental health consultation, and a significant portion of the training of the budding consultant is directed toward helping him to respond more appropriately to the effects of these factors in the consultation relationship. However, the particular importance of the consultant varying his role relationships as a tool to facilitate consultation has as yet not received the full attention it deserves.

These historical patterns may well serve to reinforce the dominant role of the physician in mental health consultation and preclude the autonomous development of non-medical professional groups having independent responsibility for consultation efforts. To the extent that these traditions remain as part of the mores of our society, all social, educational, cultural, economic, and legal disruptions within the individual or his community will continue to be seen as symptomatic of a pathological state, and the physician will remain as the only legitimate agent of society for the alleviation of these conditions. Thus, the emergence of consultation as a new discipline, incorporating its own theories, practices, and training, is not likely to occur so long as its concepts and ethics are derived as analogous translations of the concepts and ethics more appropriate to the treatment of physical pathology.

The Social Worker-Consultant

Numerically, the second largest group of consultants interviewed are psychiatric social workers. Again, as in the instance of the physician, the utilization of social workers as consultants is directly attributable to their traditional presence as staff members of medically oriented mental health facilities where they customarily function as part of a treatment team directed by a physician. In one facility visited, the entire full-time staff of the agency is composed of psychiatric social workers. This was, however, clearly an exception.

The majority of consultation programs conducted by social workers are offered to consultees having a similar, social-case-work background. However, consultation is also offered by social workers to educators and agency administrators.

Social workers were not observed as consultants to other mental health professionals such as psychologists or psychiatrists. This apparent restriction of the utilization of the social workers as consultants is in striking contrast to the wide variety of consultees receiving consultation from physicians. Furthermore, the limited use of social workers as consultants to other mental health professionals is puzzling in view of the unanimity of opinion among all consultants that social-work training uniquely exposes the prospective consultant to concepts which are mandatory for the effective performance of most types of consultation. Examples of such valuable assets include experience and training in the social, administrative, and political functioning of community organizations, an emphasis on understanding the interaction of the family and its environment, and a practical, reality-oriented approach to the solving of individual problems. However, the emphasis on environmental factors and pragmatic problem-solving is also seen as a liability, inasmuch as it occurs at the expense of a more intensive grounding in personality dynamics. Other liabilities reported include the indoctrination of the social worker as a professional whose discipline has been traditionally subordinate to that of other mental health professionals, the absence of a formal body of knowledge unique to the profession of social work, and the absence of training which permits the social worker to assume sole responsibility for decisions about treatment and disposition.

These professional liabilities contribute to the failure to use social workers in a broader range of consultation programs. It can be seen, for example, that these issues would preclude the generation of a program in which a social worker provides consultation to a physician, as this would conflict with the traditional role expectations of both the consultant and consultee. Also, with the exception of the social worker who has considerable experience in the treatment of emotional problems or training in mental health consultation, his case work background will most often channel his activities into client-centered types of consultation having

a problem-solving rather than a staff-development focus.

The evidence from the study strongly suggests that the full potential of the consultant trained in psychiatric social work is not being realized in most of those settings where consultation is offered. It also emphasizes the importance of formal training in mental health consultation of a kind which will minimize the identification of the social worker as a subordinate member of a treatment team and permit him to educate the other mental health professionals as to the value of his unique training for mental health consultation.

The Psychologist-Consultant

Although the third largest group of mental health professionals interviewed are psychologists, their consultation activities are less well delineated than those of the psychiatrists and social workers. More so than for the other mental health disciplines, the consultation role assigned to the psychologist is dependent upon his individual interests and preferences rather than upon his professional identification as a psychologist. For example, some psychologists interviewed are defined by their agency as consultants, when in fact they are providing only direct psychological services to clients of consultee agencies. This observation reflects the fact that, historically, the place of the psychologist in the mental health treatment field is more obscure than is that of either the psychiatrist or the social worker. This is true even though all the mental health facilities visited assume the psychologist has legitimate membership in the traditional treatment triad.

To illustrate some of these role variations, the psychologist sometimes encourages or permits a role definition limited to psychological evaluation somewhat akin to operating as a psychometrician. In other facilities the role perception of the psychologist is limited to that of an expert on research, to the exclusion of his participation in the service functions of the agency. In still other facilities, the assumption is made that psychological training provides expertise in programs of education, and, as a consequence, the activities of the psychologist are focused entirely on schools.

Certainly the perceptions held by the psychologist about his own versatility within the field of mental health are significant factors contributing to the roles he is assigned. Furthermore, his encouragement of this belief in the catholicity of his training facilitates his being accepted as capable of performing whatever task is assigned to him by the consultant agency. This lack of goal-directed behavior by some and intellectual arrogance of others not only affords the psychologist the luxury of investing his energies in those areas which are of special interest to him, but it prevents him from educating other mental health professionals in the utilization of those assets which are uniquely inherent in his training.

An additional barrier to the appropriate utilization of the psychologist is his tendency to resist seeing himself as a scientist whose expertness resides in his broad knowledge of human behavior and, instead, to identify with the psychiatrist physician as a pathology-oriented dispenser of treatment. This liability is particularly emphasized by the consultants interviewed and is recognized by many of them as involving the psychologist consultant in the same role confusions described for the psychiatrist.

The most significant assets of the psychologist, as reported by the consultants in the study, are his intensive training and background in the *normal* patterns of human growth and development and his knowledge of the theoretical bases of human learning. Other assets potentially valuable for mental health consultation include his background in research and his broad grasp of theoretical systems. However, in view of the observation that the largest proportion of activities currently underway and planned for the future deals directly with populations whose members are not classified as mentally ill (e.g., students and the economically and culturally disadvantaged), the role perceptions of the psychologist, both as he sees himself and as he is seen by other mental health professionals, will seriously endanger the full realization of his potential contribution to these important efforts.

Because of the limited number of consultants interviewed whose backgrounds are outside the traditional child guidance triad, generalizations about the value of their professional training for the consultation process cannot be made. It is interesting to note however that, although

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there is general acceptance among the consultants of the importance of broadening the professional base of consultation to include personnel outside the traditional mental health disciplines, such personnel are almost totally absent from the consultant staff of the facilities visited. This finding is perhaps related to the traditions associated with the medical treatment philosophy which still remain among the dominant influences in the selection of consultant staff.

Personnel Receiving Consultation: Consultees

In examining the 89 consultees as a group, one is immediately struck by the fact that 75 percent are involved in educational or welfare programs. Approximately 50 percent of the consultees are on the staff of agencies having an educational focus, and 25 percent of the consultees are employed by public or private welfare programs. The remaining 25 percent of the consultees are distributed in a roughly equal manner among the other five categories of consultee agencies.

These data are summarized in Table 4, which presents the professional background of the consultee and of his consultant. Some slight, but insignificant differences in the distribution of consultees by professional background may be noted when the tabulations of Table 4 are compared to those of Table 1 in Chapter 3, which describes the consultee by type of program rather than by professional background. Because this section of the report focuses on the implications of the professional background of the consultee, Table 4 is used as a primary reference.

Table 4 — THE PROFESSIONAL BACKGROUND OF THE CONSULTEE AND HIS CONSULTANT

Professional Background of Consultee	Professional Background of Consultant					
	Psychiatrist	Psychologist	Social Worker	Other Mental Health Professionals	Non-Mental Health Professionals	TOTALS
Social Worker (MSW or PhD)	14		6			20
Social Worker (Non-MSW)		1	4			5
Education:						
Teachers	11	3	5		1	20
Pupil Personnel Services	13	3	1			17
Administrators	4		1			5
Courts and Probation	3		1			4
Non-Professionals	1			1		2
Physician (Non-Psychiatrist)	4					4
Psychiatrist	6					6
Other Professionals (Admin. Level)	5		1			6
TOTALS	61	7	19	1	1	89

An examination of Table 4 reflects that, of the 89 consultees interviewed, only two do not have some type of professional and academic training congruent with their job responsibilities. Furthermore, approximately 75 percent of the consultees interviewed have some administrative responsibility within their agency. Table 5 describes these latter data.

Both tables indicate that almost without exception, the consultees receive professional training in disciplines which utilize procedures and teaching techniques similar to those found in some types of mental health consultation.

Table 5 — THE ADMINISTRATIVE AND LINE RESPONSIBILITIES OF THE CONSULTEES

	Executive/ Administrative	Line	Both Administrative/ Line	Totals
Educational Programs	12	8	27	47
Courts and Probation	4		2	6
Public and Private Welfare Agencies	7	8	6	21
Other Mental Health Facilities			3	3
Other Community Programs	1	1	1	3
Public Health Agencies	1	2		3
Hospitals			6	6
TOTALS	25	19	45	89

That is, the consultees were trained by means of some type of apprenticeship system wherein an expert, whether a master teacher or supervising social worker, provides information and technical assistance to the trainee. Table 4 also indicates that nine out of ten consultees are receiving consultation from professionals with a psychiatric or social work background. It is almost superfluous to observe that the training and background of these professionals relies heavily on the use of the same case-study techniques referred to above.

It is difficult to avoid the conclusion that the expectations engendered by both the academic training and the professional preparation of the consultees and consultants contribute significantly to their mutual involvement in consultation. In the case of the consultees, their required academic exposure to the ethos of the medical-treatment model, and their indoctrination in particular professions having role requirements which preclude functioning in a treatment capacity, only reinforce the necessity for their involvement with those professional groups having that prerogative. That a large number (approximately 75 percent) of these consultees have administrative responsibilities and, therefore, a decision-making voice in the policies of their agencies further contributes to the likelihood that mental health consultation relationships will be routinely included in most consultee agency programs. These factors may also make it difficult for the consultee agencies to visualize and encourage types of consultation which do not have a client-centered focus. It is also readily apparent that these conditions make it unlikely that the consultant, especially the one without formal training in mental health consultation, will initiate and maintain programs of consultation other than those congruent with the mutual expectations of himself and the consultee.

In a broader perspective, these observations delineate conditions which may have a dilatory effect on the development of community mental health programs emphasizing and depending upon the use of non-mental health professionals or untrained community workers in a treatment capacity. The traditionalistic posture that is latent in both the consultee and the consultant may thus be the single biggest barrier to the innovation of experimental community programs.

THE CONSULTATION CONTRACT

The term "consultation contract" has common usage throughout the field of mental health consultation. However, an important finding of this study is that there is a plethora of agreements that are used as the basis for conducting consultation which cannot legitimately be subsumed under the most minimal definition of the word "contract." Although the range of consultation contracts reported varies from formal legal documents negotiated by experts in contract law at one extreme to nothing more explicit than the tacit acceptance of a consultant "presence" at the other, vague agreements presumed to be in existence by both participants but never verbalized in any detail are by far the most common. In addition, the degree of formality and explicitness of these agreements is not always a function of the size of the consultant or consultee facility. For example, it is occasionally observed that some consultation programs might have a well-defined consulting agreement which is recognized and worked out by both parties prior to the implementation of the program, while within the same facility other consultation programs exist whose consulting agreements were either lost in antiquity or had never been established.

The results of this study find that a consulting agreement which merits the use of the term "contract" should contain definitions of the parameters limiting the program and its relationships, classifications of the mutual responsibilities of the contracting agencies, and agreements as to how the cost of carrying out the program will be met. Since the most generally accepted value in having a formal contract is to anticipate and negotiate, in advance, solutions to conflict situations which may arise between the contracting parties, it is not surprising that consultation programs not having any formalized agreement are unable to describe the nature of their consultation relationships and are forced to react to the expediencies of the immedate situation when such conflicts arise.

One of the implicit consequences of this ad hoc decision-making is that it is dependent upon the idiosyncratic perceptions and expectations

of the participating individuals. This factor is clearly reflected in the statements of the professionals conducting training programs in mental health consultation. They report that this technique for the resolution of conflicts between the participants in consultation inevitably leads to the untrained consultant retreating to a role relationship within which he will be most comfortable. This mental health version of Yost's Law predicts that the consultant will engage in behavioral patterns more appropriate to his earlier training as a mental health professional and that such patterns may not be consistent with the real needs of the consultation program. This issue underscores the importance of specific training in mental health consultation which will provide the consultant with a consultation philosophy stressing the importance of the contract as a prior condition to consultation. Training will also prepare him, when the occasion arises that decisions outside the contract are necessary, to utilize alternatives allowing for solutions more congruent with the requirements of the consultation program.

In less than half of the cases, the initiation of contact between the consultant and consultee agency is done by the consultee agency. In other instances, contact is initiated because members of the consultee agency have informal access to the consultant, and preliminary negotiations begin by mutual consent. However, in the majority of the programs observed, the consultees actually receiving service are not aware of the origins of the consulting relationship, nor are they privy to the contents of the consulting contract.

The consultees' lack of knowledge about their consulting contract explains the ambiguity and confusion reported by them regarding their expectations about consultation. Although the great majority of consultees expect to receive information related to developing their own professional skills (Type II Consultation), the initial structuring of consultation is often vague, deliberately ambiguous, or arbitrarily determined by the consultee agency. These conditions are frequently found to occur in consultation programs where the contracts have been negotiated by parties other than those directly participating in consultation. Even more important is the finding that the participants in the consultation relationship are often unaware of the existence of any kind of consulting contract.

The actual participants in consultation, therefore, usually structure their relationship upon variables other than those elements which might be found in a consulting contract. This obviously leads both consultant and consultee to rely on factors in their own professional training and experience to define their respective expectations and behaviors during consultation. As a result of these ambiguities in structure and role relationships, the consultee often expects consultation to be patterned after the way in which he functioned during his prior professional training, i.e., with a teacher or senior professional having some supervisory or training responsibility over him. It is not surprising, therefore, that the consultee is likely to look to the consultant to structure consultation as a teaching situation in which the consultant imparts job-related knowledge to the consultee. On the other hand, the consultant expects his role in consultation to be patterned after a set of expectations based on his prior experience with people seeking his help, i.e., in an exploratory, non-directive fashion, which is designed to elicit responses and not to provide them. The disparity between the expectations of the consultant and the consultee appears to account for the finding that the consultant's initiation of consultation is marked by a lack of structure despite the highly structured expectations of the consultees.

The absence of a contract, or the failure to orient the actual participants in consultation to the contents of the contract, frequently results in the role expectations of the consultant and consultee being contradictory. This typically produces an initial structure for consultation which is frustrating to the needs of both parties. In a larger sense, similar conflicts of needs may be observed between the agencies receiving consultation and the agencies providing consultation. Although the reason why an agency will participate in consultation is necessarily a function of its goal, other variables which may or may not be related to its mission can also influence the consulting contract. This conclusion is derived from the common observation that consultation exists for many reasons other than the usually assumed purpose of facilitating the mission of the consultee agency. The most

obvious of these is the situation in which a purpose of the agency providing consultation is to develop relationships which will permit the training of professionals in mental health consultation. This purpose will influence the choice the consultant agency will make as to the type of consultee agency solicited for use as a training facility, the conditions of the consulting contract, and the kinds of consultation activities carried out. In addition, these three variables are more likely to be assessed in terms of the way they serve the training needs of the consultant agency, with the result that the special needs of consultee agencies or the community at large may be placed in a secondary position. An example of this is reflected in the occasional observation that a consultee agency might be required to negotiate a consulting contract which would include the presence of trainees in order to be able to obtain the services of trained consultants who would be more capable of meeting the primary needs of the agencies.

Although the duality of motives is present in all training installations, in no instance are the needs of the training programs met entirely without consideration being given to the needs of the consultee agencies. Furthermore, the training installations, as a group, are usually more sensitive to the importance of clarifying these special consulting relationships through the use of formal consultation contracts than is typical of those agencies for which training is not an important goal.

Other conflicts of needs having a determining influence on the consulting contract include a lack of available funds to support the type of consultation effort necessary for a given agency, the perceptions of the consultant agency administration as to the place of the agency within the community and its priorities for service, and the nature of the cultural and economic variables characterizing the population in the catchment area of the consultant agency. This list is by no means exhaustive, but is representative of a set of factors observed as influential in determining the nature of the consulting contract.

Certainly the motives of the consultee and his agency are also important for determining the nature of the consulting contract. This importance derives uniquely from the fact that the consultee is frequently placed in the position of being sought out by the consultant as the recipient of his services. That is, the consultant agency seeks out community programs which will be willing to permit the consultant to use them as objects of consultation. This leads inevitably to the consultee agency dictating the content of the contract, if not the procedures for its implementation. Most frequently, illustrations of this influence on the consulting contract are observed in populations such as the culturally or economically disadvantaged who have become target groups for federally funded mental health programs.

Another influence of federally funded programs on stimulating mental health agencies to promote consultation is the requirement that consultation be a part of the service program of any mental health center receiving funds through the Community Mental Health Centers Act of 1963. However, unlike the populations mentioned above, the recipients of these consultation programs generally do not have to be convinced of the value of mental health consultation. Their relative sophistication about mental health services, coupled with the promotional efforts of the consultant agency, places these consultees in the particularly advantageous position of a knowledgable buyer being pressured to accept a free set of services. Further, by being in the position of the buyer, these consultee agencies can select whatever services they need and reject others. In some instances this results in the negotiation of a consulting contract which, in fact, is not consultation but a treatment program uniquely tailored to the consultee agencies' needs. Although basically a positive step in developing community mental health services, an unwanted side effect of the Community Mental Health Centers Act of 1963 has thus been the forcing of community mental health centers to include programs of consultation in their service efforts, even though they may not be fully prepared or motivated to carry them out. Indeed, it might be inferred that few centers have programs of consultation which are formulated and conducted as well as those surveyed in this study.

THE CONSULTATION MODEL

Despite the general assumption among mental health professionals doing consultation that they are operating within a set of principles which

distinguish their consultation efforts from traditional treatment modalities, the absence of consistency in the way consultation is actually conducted makes it difficult to give credence to the existence of a consultation orthodoxy which has functional utility. This conclusion derives from observations made during the course of this study that *the actual behavior of the professionals doing consultation is not congruent with the theoretical principals which they report as directing their efforts.* The only exceptions to this generalization are the very few pioneers who have devoted many years to the exploration of the unique character of consultation and who no longer see themselves primarily as traditional mental health specialists.

Three patterns orienting the behavior of the consultants toward consultation are observed. One of these, found most often among those consultants having some exposure to the principles of mental health consultation, includes an intellectual acceptance of some existing model of consultation, which is used as a loose and sometimes vague guide for defining the techniques of consultation. Another pattern is found most often in consultants who have not been exposed to the principles of mental health consultation. This group relies primarily on knowledge of the principles used in treating mental illness to provide guidelines for their consultation practice. Consultants who have had no exposure to mental health consultation but who recognize the questionable value of the use of the therapy model as a guide to conducting consultation are associated with the third pattern. These consultants typically conduct a form of consultation that is determined by the expediences of the consultation relationship and their own personal preferences.

Although these patterns provide a brief, shorthand technique for assessing the approach to consultation offered by a particular consultant within his specific agency, they also illustrate a major finding of this study that the position taken by most consultants toward consultation is highly idiosyncratic and dependent upon the consultant's traditional professional background in mental health. As has been described previously, this traditional background provides the consultant with a set of principles which can be most easily appropriated for use only in those types of consultation which are client-centered.

These findings reemphasize the importance of the development of patterns of training in mental health consultation which are consistent with the stated goals and philosophies of the agencies conducting consultation. Furthermore, they reiterate the necessity for a set of principles about consultation which are applicable to the wide variety of settings to which consultation should be applied. Seen from the standpoint of the desired end product of consultation as defined by the goals of the mental health agency, distinct combinations of principles underlying consultation become apparent which are important in understanding the directions the consultant must take if he is to be successful in carrying out these agency goals.

An examination of the range of consultation goals described by the agencies visited for this report suggests that these goals can be subsumed under three major categories which are particularly helpful in describing the relationship between the practices of consultation and the purposes of consultation. The use of these categories also provides a focus on the consequences of consultation and assists in exploring the relationship of consultation to the over-all philosophy of the consultant agency as it operates within the community.

When considered in these contexts, the three categories to which the goals of the consultant agencies can be allocated are, in fact, theoretical models which permit identification of the philosophical principles which are the basis for making pragmatic decisions such as who should receive consultation, who should practice consultation, and the form consultation should take. In addition, these models also describe the consultant's belief system regarding consultation, including his attitudes toward the proper place of consultation in the over-all field of mental health and how it should develop in the future.

The first theoretical model derives from those goals of consultation which are directed at the use of consultation as a technique for the promulgation of the tools of the mental health professional for the treatment of mental illness. The term "treatment model of consultation" appears to be most descriptive of this category. An important characteristic of this model is the assumption that maladaptive behavior is symptomatic of pathology and that the application of appropriate treatment will result in a state

of health. Adherence to this derivative of the medical treatment philosophy also dictates that the only persons who should be permitted to practice consultation should be those professionals for whom treatment responsibility has been reserved by society. A further implication that can be derived from this model is that consultation should focus primarily on the intrapsychic processes of the individual client of the consultee in the context of client-centered types of consultation.

The second theoretical model derives from those goals of consultation which are directed toward identifying and ameliorating the personal and environmental conditions which are the progenitors of psychopathology. The term best descriptive of this philosophical orientation is the "prevention model of consultation." An important characteristic of this model is the assumtion that, if the environmental conditions which are responsible for producing psychopathology are successfully changed, the treatment of mental illness will become less necessary since there will be less pathology. This model further requires that consultation should be focused on disseminating mental health principles and information to those groups and agencies within the community having the most effect on those environmental conditions responsible for pathology. Adherence to this derivative of the public health philosophy also dictates that the only persons who should be permitted to practice consultation should be those professionals having training in disciplines traditionally responsible for the health of the community or those who are in positions to influence the attitudes of community members about matters of health. This model also would require that consultants operating within this philosophy utilize the full range of types of consultation.

The third theoretical model derives from those goals of consultation which are aimed at identifying, understanding, and modifying all aspects of the total environment of the individual so as to facilitate the realization of the full potential of all members of the community. The term chosen to describe this orientation is the "enhancement model of consultation." An important characteristic of this model is the assumption that the individual and all aspects of his environment should be modified so that he will have knowledge of and freedom to choose those behaviors which are most congruent with the gratification of his needs and the realization of his potential. Furthermore, consultation should eventually be focused on all aspects of the environment, including the individual. The most appropriate immediate targets for consultation should be those groups and agencies within the community having the maximum effect on segments of the population whose current disadvantaged status most limits the realization of their potential. Adherence to this derivative of the principles of ecology also dictates that all professional and non-professional personnel having a relevant contribution to make to the goals of this model should be allowed to participate in consultation. In addition, consultants operating within this approach to consultation should utilize the full range of consultation types.

These three theoretical models of the goals of consultation, used together with the empirical model describing the procedures of consultation, are the conceptual framework for an analysis and systematic description of the consultation process as well as a discussion of the consultation programs observed in this study. An important element in the analysis of these programs was investigating the extent to which the goals of a specific agency, as implemented by their staff, are congruent with the observed needs of the consultee and his agency. However, before offering illustrations of this procedure it will be helpful to review briefly the development of the empirical model and the 18 parameters used to describe the procedures of consultation.

The behaviorally based descriptions of consultation developed for this report permitted the identification of six specific types of consultation and 18 parameters which describe variables relevant to each type. Four of these parameters were found to be definitive in differentiating each type of consultation from all others. These definitive parameters relate to the various attitudes and behaviors of the individual consultant which relate to issues about the question of responsibility. These issues were associated with problems such as the degree of responsibility the consultant assumes for case disposition, the degree to which the consultant is willing to permit his involvement in the personal process of the consultee, and the critical issue regarding the person or agency to whom the consultant is ultimately responsible. This latter issue is concerned

with the way the consultant resolves situations where conflicts of interest occur between any of the parties affected by consultation, whether client, consultee, consultee agency, consultant agency, or community.

The use of these parameters facilitates an examination of the congruence between the actual practices of consultation and the goals, attitudes, procedures, or needs of any of the participants in consultation. More specifically, responses to these parameters provide an answer to the crucial question: "How close is what the consultant doing to what the consultee needs and wants?"

Two important discrepancies between the expectations of the parties directly participating in consultation are discovered when this technique is used to analyze the data of the study. Basically, they illustrate the failure of the consultant to perceive and meet the needs of the consultee. In addition, both examples illustrate that the behavior of the consultant deviates from the theoretical model of his agency. In the first instance, the data of this study show a large percentage of consultees desiring additional services from their consultant or his agency. Typically the services requested relate to diagnosis or treatment, that is, direct as opposed to indirect services. The consultants frequently react to these requests of the consultee by providing the direct services themselves. This is found even in those cases in which the policies of the consultant agency are not determined by a "treatment model of consultation" which encourages the consultant to share treatment or disposition responsibility with the consultee. It would appear from this that the consultant is conforming to the needs of the consultee rather than implementing the goals of his own agency. However, a more detailed examination of the needs of the consultees indicates that *direct services are not being requested as a substitute for consultation but as an addition to it.* In point of fact, the consultees do not view the consultant as the appropriate person to provide these services if only because they want him to provide more consultation. In those cases where consultant time is limited, consultees typically assign priority to consultation.

In the second case, the data of the study indicate that a number of consultees want the consultant to shift the focus of consultation from the clients of the agency (Type I or Type II) to the staff of the agency (Type III). The consultants frequently react by continuing to regard the client as the only focus of consultation, even in those cases in which the policies of the consultant agency do not restrict the consultant from focusing consultation on the personal processes of the consultee. Apparently, the majority of consultants from whom this type of service is requested consider it inappropriate to their role. Instead, they maintain the position that the only way in which the personal processes of the consultee can intrude into consultation is indirectly through discussions focusing on the client.

Both of these examples, illustrative of the failure of consultation to meet the needs expressed by the consultees, are related to problems and issues regarding the training of mental health consultants. The first example, in which the consultant fails to perceive that it is not necessary for him to provide the direct services requested, demonstrates the importance of his prior training as a treatment-oriented professional to his role behavior in consultation. These attitudes are particularly apparent in those consultants who have had no training in the consultation process itself.

The second example is illustrative of a philosophy of consultation which stresses the principle that the personal processes of the consultees are not appropriate topics for direct discussion. This orientation is seen most frequently in those consultants who have had some formal training in mental health consultation. Both of these examples concern issues of importance to training in mental health consultation. In addition, this latter example is specific to the issue of whether or not current mental health consultation training is adequately preparing consultants to perceive and meet the needs of their consultees.

A critical factor underlying this orientation to the training of the mental health consultant is the principal that the consultant and the consultee are status peers whose relationship to each other is determined by their respective bodies of expert knowledge. This leads necessarily to the position that the personal processes of the consultee are not an appropriate subject for the consultation interaction. The corollary principles derive from the ethical position inherent in the medical model that the relationship between patient and physician precludes the development of relationships of another kind. This factor is particularly emphasized within

the field of psychotherapy, where it is considered axiomatic that a therapist does not treat friends.

The approach taken by this study to the examination of mental health consultation suggests two fallacies in the rationale underlying the above-described orientation to consultation. The first is the position that any exploration into the intra-psychic processes of the consultee is synonomous with psychotherapy. This position ignores the existence of a body of knowledge and techniques for exploring intra-personal and inter-personal interactions which are not based on the assumption of pathology. In recent years, an increasing use of group dynamics in helping normal people achieve a greater degree of self-actualization demonstrates that open discussions of feelings need not be seen only as psychotherapy for sick patients.

The second fallacy, related to the necessity for an egalitarian peer relationship, is refuted by the findings of this study, which suggest that the status relationship most desirable to facilitate the types of consultation these consultants prefer to make available (Types I and II) is that of an authoritative expert rather than that of an egalitarian peer. Similarly, the type of consultation requested by the consultees (Agency-Centered Staff Development, Type III) does not require a peer relationship but rather the maintenance by the consultant of a role as an authoritative expert.

Undoubtedly one contribution to the observed disparity between the theories underlying the teaching of mental health consultation and the actual techniques by which it is carried out is the finding that many consultants have rejected their role as an expert and have reinterpreted the meaning of peer to be synonomous with friend. Were these consultants to adhere to the formal definition of the peer relationship as provided to them during their training in consultation, they would be able to retain a position of authority based on their expert knowledge. Similarly, if they relied on the authoritative status relationships which are a part of their traditional training as mental health professionals, less confusion would develop between the expectations of the consultee and the behavior considered appropriate by the consultant.

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Chapter VI

Conclusions and Recommendations

CONCLUSIONS

An examination of the facilities and personnel participating in consultation activities reveals clearly the dominant influence of the medical model on consultation programs currently in operation throughout the United States. This influence is especially apparent in the frequently observed philosophy of consultation which conceives of the mental health consultant as at the apex of a treatment pyramid made up of other professionals trained by the consultant in the treatment of mental illness. Despite the prevalence of this view of consultation, many consultants interviewed express the opinion that the history, tradition, and theories inherent in the medical treatment model may not be entirely appropriate to the consultation process. The need for models that are defined in terms other than those of psychopathology is further emphasized in the universal priority given to developing programs of consultation directed toward populations which can be appropriately described only in terms of social, cultural, educational, or economic phenomena. The rationale for the treatment pyramid philosophy of consultation derives directly from the growing awareness throughout the mental health community that the individual professional is no longer able to meet the treatment needs of the community through his own personal efforts.

The apparent conflict between those consultants who believe the medical model is no longer appropriate and those who believe it is necessary depends on the assumption that a single model of consultation is applicable to all situations. The observations made in this study reveal repeatedly that consultation programs exist for which the treatment pyramid paradigm is not only reasonable but necessary to provide a community with the minimum services basic to its mental health needs. Examples related to these observations are found in areas of low population density where mental health facilities simply do not exist. On the other hand, mental health agencies in large urban centers have directed their energies into programs of intervention within the community that are designed to prevent mental illness rather than treat it. Within this public health model, the segments of the population requiring these services are not themselves mentally ill but are viewed as carriers of mental illness. The cultural, social, economic, and educational factors which contribute to this pathology are the etiological variables that are the objects of the preventive efforts.

The intrinsic assumptions about psychopathology which are inherent in this variant of the medical model are viewed by many consultants as restrictive of their efforts in coping effectively with the urgent social crises facing urban communities today. They believe that neither a medical model based on treatment nor one based on the prevention of pathology is appropriate to problems such as revising the educational system, resolving the tensions between the larger society and those racial, ethnic, and economic minorities who are the object of discrimination and deprivation, and, on a still larger scale, resolving the conflicts between nations. These consultants suggest that the model for such programs should evolve from the principles of ecology—that is, from a consideration of the influence of all aspects of the total environment on the dynamic growth of the individual. Furthermore, the individual and the environment are seen as participating in a continuous reciprocal interaction. The results of any given interaction are not confined to the immediate participants but ultimately will have an effect on many seemingly unrelated facets of society.

Implicit in this enhancement model is the assumption that it is possible for a consultant to structure this interaction process so as to generate conditions facilitating the positive growth of the individual and his community toward the full realization of their potential. This focus on the positive aspects of human development precludes the continued use of terms and constructs which constitute a theoretical framework that should be reserved for the treatment and prevention of psychopathology. The continued misapplication of terms and constructs rooted in pathology within programs of consultation more aptly described by this cultural enhancement model produces unnecessary confusion and conflicts for consultants involved in these programs. Secondarily, the Procrustean attempts of mental health professionals to apply these medical constructs where they no longer fit has delayed the development of new constructs and terms that are needed to delineate this non-medical model of consultation.

The ethical issue as to the basis by which the mental health professional considers social or economic problems to be a legitimate focus for his efforts has not yet been resolved. Some members of the professional community have expressed the opinion that mental health specialists should restrict their activities to the diagnosis and treatment of mental illness in those patients who seek their help. At the other extreme, there exists a number of mental health experts who state that the principles and knowledge of the behavioral sciences can legitimately be imposed on all aspects of human existence. These issues and the manner of their resolution will have a profound influence not only on the training and curricula of mental health consultation but on the decisions as to which professional areas are the most appropriate for the recruiting of prospective consultants.

In order to amplify more fully the implications of these theoretical positions assumed by the consultants interviewed, an attempt has been made to abstract and make systematic those observations which are relevant to the training and selection of mental health consultants. The variables listed are not meant to be exhaustive but representative of the most important factors likely to contribute significantly to training and selection.

Treatment Model of Consultation—Training and Selection

Those consultants who recognize the importance of the treatment model that is derived as an extension from traditional medical practice emphasized the following training and selection variables:

- A continuation of and increase in the recruitment of professionals with medical and psychiatric training for training in consultation
- Training which emphasizes those types of consultation which have a client-centered focus (Types I and II)
- Training which provides an exposure to and discussion of the professional areas and administrative structures of those consultee agencies whose programs have specific caretaking or direct treatment responsibilities
- Training which provides an awareness of the necessity for the consultant to assume or share responsibility for treatment programs which will be carried out by non-medical professionals or non-professionals
- A capability and desire to teach mental health principles to others using techniques derived from training in the traditional mental health professions
- An interest and ability to seek out and promote mental health consultation to agencies having treatment needs
- Personal comfort and experience in dealing with groups of treatment-oriented professionals rather than individuals
- A personal preference for programs of consultation which have immediate, detectable effects on a relatively small number of beneficiaries

Prevention Model of Consultation—Training and Selection

Those consultants who recognize the importance of the prevention model derived from the public health approach to physical disease emphasize the following training and selection variables:

- A continuation of and increase in the recruitment of professionals with medical and psychiatric training to serve not only as consultants but as program administrators
- Training programs which include non-medical experts having special knowledge of demographic and epidemiological variables and the techniques for their investigation
- Training programs which include exposure to the principles and practices of public health

as well as an emphasis on those types of consultation which have a program or community focus (Types IV and V)

- Training programs which include an exposure to and a discussion of the administrative and political structure of community organizations as well as familiarity with the professional requirements of a broad range of community agencies
- Training programs which focus on the techniques and procedures appropriate to the training of non-medical professionals and non-professionals to assume and share the role of the mental health professional in the promulgation of mental health principles leading to the prevention of psychopathology
- A capability and desire to teach mental health principles to large segments of the public through the use of existing community organizations
- An interest and ability to seek out and to promote programs of mental health consultation at the community level
- Personal comfort and experience in dealing with large groups as well as individuals
- A preference for programs of consultation which influence large numbers of people slowly over a long period of time

Enhancement Model of Consultation—Training and Selection

Those consultants who recognize the importance of an enhancement model of consultation which is derived primarily from the principles of ecology emphasize the following training and selection variables:

- A deemphasis on the use of professionals having medical and psychiatric training and an increased emphasis on the use of mental health and non-mental health personnel from a wide variety of professional and academic disciplines
- Training programs which focus on the development of consultation as an independent discipline which derives its content from the full gamut of social sciences as well as those disciplines directly related to mental health
- Training programs explicitly designed to reduce the status differential between the various consultant disciplines on the assumption that a status hierarchy based on professional background is irrelevant to and interferes with the process of consultation
- Training programs which include preparation for the assigning and sharing of traditional legal and professional responsibilities for treatment with other professional and non-professional personnel in ways which are unique to the requirements of specific programs and for which there may be no precedent
- Training programs which include experiences promoting the ability of the consultant to interact comfortably and appropriately with community members in activities and situations which may be alien to the consultant but which are characteristic of the population of the community with whom he is consulting
- Training programs which provide a discussion of an exposure to a range of cultural and social folkways as well as the organizational structures indigenous to those communities most likely to be the recipients of consultation
- Training programs which focus on the development of techniques and procedures appropriate to training of members of the community in the development of self-sustaining programs that will maintain the impetus and direction initiated through consultation
- A preference for programs of consultation which affect those segments of the general population whose maximum potential has been least realized

The analysis of the data relating to the areas of the consulting contract and the consultation model suggests that few innovative or definitive statements can be isolated which are helpful to the training of the new consultant or are uniquely advantageous to the variety of consultation programs currently in existence. In general, the analysis of these data reflects strongly the imperative necessity that the variety of consulting contracts and ways of conducting consultation prevalent at this time must first be ordered into some system before specific recommendations as to the value of a given contract or procedure can be made. Although the emiprical model of consultation offered by this report permits such a systematic analysis, the model itself has not yet been tested and can presently be used only as an heuristic tool.

However obvious it may be, it is also necessary to state that an important finding of this study is that the clinical practice of consultation requires, prior to the initiation of the program, the negotiation of a formal contract which defines the type of consultation, the procedures to be employed, the personnel to be used, and the source of financial support. It is the very lack of these explicit statements defining the roles of

the participants in consultation which leads to the frustration, confusion, and wide technical variation that make a unitary description of consultation so difficult.

The lack of a consultation contract also precludes any analysis of the evolution of consultation as a process. That is, it prevents the observer as well as the participants of consultation from developing an appreciation of the potential direction consultation might take. This is particularly detrimental to those consultant agencies whose staff members have had little experience in consultation. Their lack of perspective frequently forces them into the view that consultation is a necessary routine to be endured or tolerated. In other instances their lack of experience with consultation models and contracts may make it difficult for them to recognize the appropriateness of their creative, indirect service programs because they do not happen to fall within a consultation framework described by a particular theoretician.

In addition to obscuring the ability of the consultant to engage in a kind of longitudinal analysis of his potential in mental health consultation, the absence of the contract also denies to the consultee an appreciation of the growth and development which the total range of consultation activity can provide for him. In this instance, as in the others, it is again the consultant's lack of training in the principles of mental health consultation which makes it almost impossible for the consultee to have access to such information. Implied in these observations is the further assumption that any mutual recognition of the necessity for a consulting contract between the consultant and the consultee will lead the consultee to grasp the real significance of his powerful position as a source of sanction for the behavior of the consultant, as well as a collaborator who participates in the decisions about consultation. Although the possibilities might seem remote, one must still speculate about the effects of this implication as a determining force in the confusion observed in the procedures and techniques of mental health consultation as it is currently practiced. From a theoretical point of view, this conclusion is a tenable one. Writers in the field of mental health consultation have described the importance of training the consultant to recognize the expert status of the consultee as a first step in the development of a consulting contract which will be mutually satisfactory to *both* parties. These authors have also emphasized that the consultant's acceptance of the status of the consultee provokes anxiety in the consultant because it deprives him of his familiar role as an authoritative expert with absolute responsibility for life-and-death decisions. For this reason, among others, training in mental health consultation is important if the consultant is to be effective.

This finding, that training in mental health consultation is of critical importance to the functioning of the consultant, has been explored in many contexts throughout the body of this report. Illustrations have been offered describing the effects of the training of the consultant on the consulting relationship, on the consulting contract, and on the actual procedures and practices of consultation. More salient, however, has been the conclusion that training in consultation is necessarily dependent on the development of a theoretical framework which will permit the description of a set of variables about consultation susceptible to experimental test. This report has attempted to offer both the theoretical framework and a set of variables necessary for the development of such an experimental model of consultation.

RECOMMENDATIONS FOR RESEARCH

The two most important findings of this study, both of which are prerequisites for the conduct of systematic research on mental health consultation, are as follows:

- Consultation as typically practiced throughout the country lacks the consistency of procedure and method necessary for the experimental validation of its effectiveness. This is the consequence of the lack of a uniform set of constructs leading to the description of the practices and procedures of consultation for which they are used.
- There is a general lack of recorded information about consultation practices which makes descriptive or experimental research about mental health consultation almost impossible. Furthermore, those limited records which are available are neither uniform as to the way in which the information is recorded nor consistent as to the kinds of information obtained.

Implications derived from these findings can be analyzed in terms of procedures which are appropriate to the assessment of any problem

requiring experimental research. These procedures must include the development of constructs defining the specific nature of consultation, the isolation of parameters which describe the specific procedures of consultation, the development of tools for the measurement of the behaviors defined by the parameters, the generation of additional constructs permitting the identification and definition of the general and the specific purposes of consultation, and the definition of criteria to validate the effectiveness with which consultation meets its stated purposes. A recommendation of the specific manner in which these general requirements can be achieved derives logically from this conclusion.

- Agencies having consultation programs must conduct their activities with a consistency of procedure and method which is required for systematic research. Therefore, it is necessary for these agencies to develop a set of constructs about mental health consultation which permits the description of the types of consultation each agency will utilize so that consulting programs will have a focus and direction which is consistent with the central purposes of the agency.

The analysis of the data from this study has permitted the development of specific constructs relevant to the definition of the nature of mental health consultation which order consultation activities into seven discrete types. The 18 parameters which isolate and describe the behavioral components appropriate to each of these seven types of consultation have also been developed in this study. In addition, three constructs have been generated which allow for the identification and definition of the general and specific purposes of mental health consultation. Recommendations of specific ways in which these derivations from the data of this study can be utilized in systematic research on mental health consultation are presented below:

Research Focused on the Nature of the Consultation Process

- To test the relative effectiveness of an egalitarian peer relationship as contrasted to an authoritative relationship for performing client-centered consultation.
- To test the relative effectiveness of acceptance or denial by the consultant of responsibility for treatment decisions in client-centered consultation.
- To test the relative effectiveness of techniques of consultation which focus directly or indirectly on the personal processes of the consultee.
- To test the relative effectiveness of the several mental health disciplines for the conduct of different types of consultation.
- To test the effect of the professional status of the consultant and the consultee on the conduct of consultation.
- To test the relative effectiveness of training in mental health consultation for the conduct of different types of consultation.

Research Focused on the Recipients of Consultation

- To examine the nature of the changes in consultees relative to the type of consultation received.
- To examine the relative effectiveness of different types of consultation on various target populations.
- To study and describe those characteristics of target populations which define sub-groups most likely to benefit from consultation programs.
- To study the effectiveness of the use of nonprofessional personnel as collaborators in mental health consultation programs.

These suggestions are by no means exhaustive, and other specific research efforts could be outlined in similar fashion. This approach to research on consultation will eventually result in the development of procedures of training and the establishment of theoretical models for consultation which go far beyond those outlined in this report. A systematic approach to research will also permit decisions to be made related to the cost-effectiveness of particular types of consultation for specific target populations. Motivational factors related to the target populations can be included in such an assessment so that the meaning or value to the individual of any change in his behavior which results from consultation can also be included in the cost-effective paradigm. This particular variation of the paradigm has been described by Behavior Science Corporation as "cost-behavior-effectiveness" or COBEEF. Its uniqueness derives from the inclusion of motivational variables into the cost-effectiveness model so as to ensure a more humanitarian assessment of the worth of a program.

However, before any programs of research can be instituted, the establishment of a data collection, storage, and retrieval system must have first priority. Decisions regarding such issues as the appropriate target groups for

investigation, the nature of the independent variables, the methods of sampling, and so on, cannot be contemplated until systematic information is available. The only alternative is to continue to support small-scale, experimental research which cannot be generalized to other populations, which may be of questionable validity, and which may be fragmented theoretically.

RECOMMENDATIONS FOR DATA MANAGEMENT

- The second major finding of the study, that there is a general lack of recorded information necessary for the conduct of research in mental health consultation, leads to the recommendation that systems for data acquisition, storage, and retrieval be developed and used uniformly in those agencies responsible for the conduct of mental health consultation.

In order to develop adequate programs of research in the area of mental health consultation, several factors must first be considered. The most important of these is the ability of these proposed research programs to have access to data which are necessary for the testing of experimental hypotheses. To do this most effectively it is necessary not only that the raw data be accessible but that it can be stored for use at a later time and easily be retrieved as new research programs requiring its use become available. A third factor, frequently overlooked by many research programs, is the requirement that pertinent information describing the research has wide and rapid dissemination to all those professionals who may be involved in the same areas of research. These three variables, and the sub-sets which derive from them, are seen as having particular importance in directing the research efforts of the National Institute of Mental Health in the area of mental health consultation for children.

It was observed throughout the course of this study that the facilities visited had few systematic procedures for the accumulation of information necessary to initiate research programs in consultation. Nor did they have available a set of uniform administrative procedures which would permit data from one center to be compared with the data from another. This lack of uniformity, both in the kinds of data and in the manner used to collect it, has made virtually impossible the development of research programs which have a national, regional, or even statewide focus. Two conclusions follow from this finding:

- The National Institute of Mental Health should initiate the development of uniform procedures of data management necessary for the conduct of research in mental health consultation.
- The National Institute of Mental Health should assist and guide the application of these procedures within the administrative framework of all mental health programs having data pertinent to research on mental health consultation for children.

Procedures permitting both uniform access to data and technique for data storage and retrieval can best be implemented by the installation of a management information system (MIS). This administrative tool is an organized combination of personnel, facilities, electronic data-processing (EDP) equipment, procedures, and communication networks designed to make available data which are current, accurate, and complete. In addition to its research potential, this management information system will provide local, regional, and national mental health agencies with the information necessary for effective decision-making relating to both short-term and long-range requirements for funds, services, and personnel. Such a system will also permit the development of efficient, economical, administrative services which will improve the day-to-day operations of the individual centers using it.

Of critical importance to the development of this system for research purposes is the necessity to protect confidential patient data so as to ensure individual anonymity and guarantee the right of the patient to have information about him withdrawn from the data pool. Such a safeguard can be built into the design of the system.

This management information system will permit the implementation of the third factor described as important for the development of a research program. Information pertinent to research can be quickly and easily transmitted through the use of MIS. Rapid flexibility of response will not only allow the individual professional to utilize those research findings appropriate to his clinical practice but will also allow individual professionals to channel their energies into research activities which are not duplicated elsewhere. This feature will provide a more systematic technique for the disburse-

ment of research funds and will probably stimulate the development of additional research as rapidly as the system becomes operational.

It is therefore recommended that the National Institute of Mental Health undertake the development of a management information system (MIS) which will permit the availability of research data appropriate to mental health consultation and allow for the development of uniform administrative procedures within mental health agencies at local, regional, and national levels. A precursor to the development of this system is a planning phase during which a systems design would emerge. The principal issues would include:

- Determination of the amount and types of information which must be accessible to or available from a given mental health agency
- Determination of a uniform set of administrative procedures for collection, storage, and retrieval of data
- Determination of the most efficient administrative level of the National Institute of Mental Health (e.g., local, regional, or national) for the collection and storage of data

With the introduction of a management information system, it will be possible for the National Institute of Mental Health to generate a Planning, Programming, and Budgeting System. This system (PPBS) will provide NIMH with techniques required for selecting the best possible allocation of the resources under its control. For example, a PPB system would permit a systematic method for obtaining maximum benefit from programs of mental health consultation offered to children through the efficient application of available program resources. A properly designed PPBS makes the consequences of various allocations, whether of funds, personnel, facilities, or materials, explicit in terms of the accomplishment of goals, the cost of resources, and the current and future costs to other programs.

An efficient PPB system could be designed for the National Institute of Mental Health based on the following three principles:

- The existence of an *analytic* capability that carries out continuing in-depth analyses of the relationships between programs and program objectives
- The existence of a *multiyear planning and programming* process that incorporates and uses an information system to present data in meaningful categories essential to the making of major decisions
- The existence of a *budgeting* process that can take broad program decisions, translate them into more refined decisions in a budget context, and present the appropriate programs and financial data for action

Assuming that the PPB system would adhere to these basic principles, the following would be included among its essential elements:

- A program structure that presents data on all of the operations and activities of mental health centers in categories that reflect the center's end purposes or objectives
- The analyses of possible alternative objectives of the centers and of alternative programs for meeting these objectives which result from the carrying out of broad systems analyses in which alternative programs are compared with respect to both their costs and their benefits
- An adherence to a time cycle within which information and resulting recommendations are produced at the times needed for decision-making, including decisions about budget and legislative programs
- An acceptance by line officials, with appropriate staff support, of responsibility for the establishment and effective use of the system

The system will have many products, the major ones of which should include:

- Multiyear plans, including a systematically updated multiyear output plan (MYOP), a multiyear financial plan (MYFP), and a multiyear manpower plan (MYMP)
- System analyses, including program memoranda, prepared annually and used in budget preview, special studies, and other requirements which would contribute to annual program planning

Finally, the capabilities that the PPB system would impart to its developers and users include its ability to do the following:

- Spell out more concretely the current objectives of community mental health center programs
- Evaluate thoroughly and compare the benefits and costs of current and alternative programs
- Produce estimates of total, rather than partial, program costs and benefits
- Present, on a multiyear basis, the prospective costs and accomplishments of programs
- Perform PPB on a continuing, year-round basis, instead of on a crowded schedule to meet budget deadlines

- Make available to top management more concrete and specific data relevant to broad decisions

- Analyze systematically and present possible alternative objectives and alternative programs for review and decision

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Appendix A

MENTAL HEALTH CONSULTANT QUESTIONNAIRE

Name of Consultant _____ Date _____
Agency _____ Title _____
Profession _____

1. What kinds of services do you provide?
   Consultation _____
   In-service training (Formal presentation within specific agency) _____
   Educational Programs (General public or educational institution) _____
   Direct Service to Clients _____ Consultation on Research _____
   Other _____
2. Do you have any priorities or preferences for the kinds of service provided?
   Yes _____ No _____
   2a. (If Yes) What are they?
3. How many consultants are on your staff and what are their professional backgrounds? (*Director only*)
   Full Time: (Including professional backgrounds)
   Part Time: (Including professional backgrounds)
4. Do you charge a fee for consulting services? (*Director only*)
   Yes _____ No _____
   4a. (If Yes) How is this fee determined?
5. To whom do you offer consultation services? (*Director only*)
   5a. Individuals
   5b. Agencies
6. How do you bring your services to the attention of and sell them to new agencies? (*Director only*)
7. What are your purposes and goals when carrying on mental health consultation?
8. In the consultation role as such (not including direct service to clients), to what degree do you have contact with the client either through interviewing or direct observation?
9. Do you offer direct clinical services when the consultee discusses very difficult problem children and requests your help?
10. Is it necessary for a consultant to become familiar with the organization and political structure of an agency to be an effective consultant?
    Explain.
    10a. (If Yes) How is this accomplished and how long does it take?
11. As a consultant, do you primarily meet with individuals, groups, or both?
    Explain why.
12. When consulting with groups do you include people from different agencies?
13. Do you make it a practice of including a supervisor and his subordinate(s)?
    Explain.

14. Are any special approaches needed when consulting with *consultees* who are from minority races and lower socioeconomic groups or with consultees who deal with these groups as clients?

15. Does your organization ever use more than one consultant to the same agency (as the individual school and *not the school district*) or more than one consultant in the same group meeting?

    Explain.

16. How frequent must consulting contacts be to be effective?

17. On whose premises does consultation usually take place?

18. Do you keep notes or records of consultation sessions?

    Yes _____ No _____

    (If Yes) For what purposes and how are they used?

19. How do you start consultation with a new group or in a new setting?

    Do you provide a structure?

20. Do you ever use direct service to open the door to consultation?

    Yes _____ No _____

    (If Yes) Do you attempt to disengage from direct service and is there any problem of who has responsibility for the case?

21. What kinds of status relationships do you attempt to maintain with consultees?

22. In the course of consultation do you sometimes suggest the referral of some problems to other agencies?

    Explain.

    22a. Roughly what percentage of cases do you refer?

23. How do you determine if the difficulty a consultee is having with a client is due to the client's problem or a personal problem of the consultee's?

24. Do you focus on the consultee's personal problems directly or only indirectly through discussion of client problems?

25. What avenue do you pursue when you find a consultee who is unamendable to change through your efforts and is potentially even harmful to clients?

26. How do you attempt to help consultees with what might be described as "hopeless" clients?

27. Now, would you briefly describe one of your most successful consulting experiences, also including the problem, your goals and the outcome?

28. Now briefly describe one of your least successful consulting experiences, also, including the problem, your goals and the outcome.

29. Is consultation ever terminated?

    Explain.

30. What personal qualities contribute to being a good consultant?

31. What are the characteristics of the following professional backgrounds which assist or interfere with effective consultation?

    31a. Psychiatrists

    31b. Psychologists

    31c. Psychiatric Social Workers

    31d. Other Mental Health Workers

32. Have you had any specific training in mental health consultation?

    32a. How has this aided or hindered your consultation practice?

33. Should non-mental health professionals be allowed to practice mental health consultation?

    Explain.

34. How do you evaluate the effectiveness or impact of consultation on the agencies

and individuals with whom you consult?
Explain.

35. When is consultation most effective? For example, at the beginning of service to an agency, after many contacts, where there has been a crisis, etc.
36. When does consultation do some harm or seem to be contraindicated?
37. What groups, institutions or situations do you see as placing the greatest demand for professional consultation services in the future?
38. What trends or directions do you see for mental health consultation in the future?
39. What are the major questions in mental health consultation that need to be answered through research?
40. What do you feel should be the "critical" test or criteria for measurement as to whether consultation has been effective or not?
41. Who do you feel are the leaders in the mental health consulting field?
42. Do you have any additional comments?

Appendix B

MENTAL HEALTH CONSULTEE QUESTIONNAIRE

Name of Consultee _____ Date _____

Agency _____

Title _____ Profession _____

1. How long have you been using the consultation provided by (name of consultant organization providing services to this person)?
2. How was consultation first arranged and who made the initial contact?
3. When you went into consultation what did you hope to get out of it?
4. When you first met with the consultant, how did he describe what he would be doing?
5. How did you convince your own board of the need for consultation rather than direct clinical services? (*Director only*)
6. How frequently and for what length of time do you meet with your consultant?

   6a. What time of day do you meet?
7. Considering the many demands upon you for your time, is the amount and frequency of consultation satisfactory, or too much, or too little?

   7a. Do you have any plans for increasing or decreasing consulting services?
8. What is the professional background of your consultant?

   Psychiatrist _____ Psychologist _____ Social Worker _____
9. What percentage of the consultant's time is spent in meeting with groups and what percentage of time with individuals?

   9a. (If in a group) What is the makeup of the group? (Professions and administrative level and size)

   9b. Do you see advantages or disadvantages to meeting in a group or individually?
10. What do you find most helpful about your sessions with the consultant?
11. What kinds of problems are discussed during the consultation sessions?
12. Do you feel there should be additional subjects brought up for discussion?
13. Does the consultant give specific suggestions for handling problems and are these helpful?
14. Does the consultant ever suggest referring a problem to an outside agency for help? If he refers you to outside agencies, how specific and helpful is he with these referrals?

    14a. What kind of agencies are referred to?

    14b. Roughly what percentage of cases are referred?
15. Are there additional types of services you would like to receive from your mental health consultant?
16. What changes would you like to see in the way your consultant operates?
17. Sometimes people from various professional disciplines encounter some difficulty

in communicating clearly with each other. Has this been a problem at all in using mental health consultation?

Explain.

18. Do you feel that your consultant is sufficiently familiar with your profession and operation to be of practical help?

Explain.

19. Do you feel your consultant respects your professional judgment in your own field?

Explain.

20. I wonder if you could describe a particular situation where you feel the consultant provided some help that you found to be useful?

21. On the basis of the consultation you have received, is there anything that you are now doing differently in your daily work?

Yes _____ No _____

(If Yes) What is this?

22. Are there any other comments that you have about consultation in general or your specific experiences?

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